North Carolina

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2018

End Year 2019

State DUNS Number

Number 80-978-5363

Expiration Date

I. State Agency to be the Grantee for the Block Grant

Agency Name NC Department of Health and Human Services

Organizational Unit NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Mailing Address 3001 Mail Service Center

City Raleigh

Zip Code 27699-3001

II. Contact Person for the Grantee of the Block Grant

First Name Jason

Last Name Vogler

Agency Name DMHDDSAS, NC DHHS

Mailing Address 3001 Mail Service Center

City Raleigh

Zip Code 27699-3001

Telephone 919-733-7013

Fax (919) 508-0951

Email Address jason.vogler@dhhs.nc.gov

III. Third Party Administrator of Mental Health Services

First Name Richard

Last Name Topping

Agency Name Cardinal MCO

Mailing Address 550 S Caldwell

City Charlotte

Zip Code

Telephone 704-939-7700

Fax

Email Address

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

V. Date Submitted

Submission Date   8/31/2017 6:30:48 PM

Revision Date   12/19/2017 9:19:45 AM

VI. Contact Person Responsible for Application Submission

First Name   Ken

Last Name   Edminster

Telephone   919-715-2774

Fax   919-508-0962

Email Address   ken.edminster@dhhs.nc.gov

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Section	Title	Chapter
Title XIX, Part B, Subpart II of the Public Health Service Act		
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mandy Cohen MD, MPH _____

Signature of CEO or Designee[1]: _____

Title: Secretary _____   Date Signed: _____

                                                         mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

Office of the Governor
State of North Carolina

Roy Cooper
Governor

20301 Mail Service Center
Raleigh, N.C. 27699-0301

May 15, 2017

Ms. Virginia Simmons, Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20850

Dear Ms. Simmons:

As the Governor of the State of North Carolina, for the duration of my tenure, I delegate authority to the current Secretary of the North Carolina Department of Health and Human Services, or anyone officially acting in this role in the instance of a vacancy, as the state mental health authority (SMHA), for all transactions required to administer the Substance Abuse and Mental Health Services Administration's (SAMHSA) Community Mental Health Services Block Grant (MHBG).

Very truly yours,

Roy Cooper

cc: Mandy Cohen, MD, MPH

Location: The State Capitol Building, Raleigh, N. C. 27602
Phone: 919-814-2100

Printed: 12/19/2017 9:20 AM - North Carolina - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020   Page 86 of 130

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

February 13, 2017

<u>Memorandum</u>

From: Mandy Cohen, MD, MPH
        Secretary

Re: Delegation of Authority

As of this date, I am delegating my signature authority to Christen Young, Deputy Secretary for Policy and Operations; Dale Armstrong, Deputy Secretary for Facility Based Behavioral Health and Developmental Disabilities Services; Rod Davis, Chief Financial Officer; Dave Richard, Deputy Secretary for Medical Assistance; and Mark Benton, Deputy Secretary for Health, for the Department of Health and Human Services. During such times as I designate, Ms. Young, Mr. Armstrong, Mr. Davis, Mr. Richard or Mr. Benton may have the authority to sign official Departmental documents for which my signature is required.

Any such documents will have the same force and authority as if they had been signed by me.

Such authority continues until revoked by me, either orally or in writing.

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

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Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Mandy Cohen MD, MPH

Signature of CEO or Designee[1]:   _✓ Mark T. Benton for MC_

Title: Secretary

Date Signed: 8/18/17

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Printed: 8/15/2017 3:42 PM - North Carolina - OMB No. 0930-0168 Approved: 06/12/2015 Expires: 09/30/2020   Page 6 of 79

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State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
Standard Form LLL (click here)

Name

Mandy Cohen MD, MPH

Title

Secretary

Organization

NC Department of Health and Human Services

Signature: Date:

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)
Standard Form LLL (click here)

Name

 Mandy Cohen MD, MPH

Title

 Secretary

Organization

 NC Department of Health and Human Services

Signature: ✓ _Mark T. Benton for MC_   Date:

Footnotes:

Disclosure of Lobbying Activities
Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
a. contract _B_ b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	a. bid/offer/application _A_ b. initial award c. post-award	a. initial filing _A_ b. material change **For material change only:** Year _____ quarter _____ Date of last report _____

4. Name and Address of Reporting Entity: _A_ Prime _____ Subawardee Tier_____, if Known: **North Carolina DMH/DD/SAS** **306 N Wilmington St** **Raleigh, NC** **Congressional District,** *if known:*	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: N/A **Congressional District,** *if known:*
6. Federal Department/Agency: SAMHSA	7. Federal Program Name/Description: **Projects for Assistance in Transition from Homelessness** CFDA Number, *if applicable:* __93.958_____
8. Federal Action Number, *if known:*	9. Award Amount, *if known:* $ $11,276,091
10. a. Name and Address of Lobbying Registrant *(if individual, last name, first name, MI):* N/A	b. Individuals Performing Services *(including address if different from No. 10a)* *(last name, first name, MI):* N/A
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: _Mark T. Benton for MC_ Print Name: __Mandy Cohen MD, MPH___ Title: _Secretary of NC DHHS____ Telephone No.: _____ Date: _____
Federal Use Only	Authorized for Local Reproduction **Standard Form - LLL (Rev. 7-97)**

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

ADULT MENTAL HEALTH

System Overview

North Carolina is actively working on developing an adult mental health service array that is able to meet individuals where they are at in the community of their choice. Our focus in the coming years will be on ensuring that services of varying intensity are available and accessible, that they pull from evidence based practices when available, and that we make frequent and appropriate use of peer led interventions to infuse our service array with recovery and wellness practices.

Evidence Based Practices (EBPs)

- **Assertive Community Treatment (ACT)**
  NC has invested a significant amount of funding in improving the quality of ACT services provided across the state, and ensuring that ACT staff have access to training that supports their implementation of ACT. NC understands that ACT is an invaluable tool in supporting adults with severe and persistent mental illness live in and be part of community. We will continue to conduct fidelity evaluations using the Tool for Measurement of ACT (TMACT) and identifying areas of technical assistance to focus on across the state.

- **Individual Placement and Support – Supported Employment (IPS-SE)**
  IPS-SE has been part of the NC AMH Service Array since 2013. This service and practice is still very new to the State, and as such, NC has invested a significant amount of funding in ensuring that IPS-SE teams have access to training and technical assistance to support good implementation. NC has also written into the ACT policy/service definition that all teams will have a vocational specialist, and the vocational specialist will be trained in and provide services in a way that aligns with the IPS-SE EBP. NC will continue to focus on ensuring IPS-SE is accessible across the state, and that new and existing teams have access to training and technical assistance. We are actively working on the pilot implementation of an outcome and performance based payment system that will sequence funding with NC DVR milestone reimbursement system. We strongly feel that this payment system will support providers in being able to focus more on high quality implementation of IPS-SE, and less on excessive paperwork required for authorization.

- **Critical Time Intervention (CTI)**
  Critical Time Intervention was added to the State funded service array in 2016 to support adults with severe and persistent mental illness through critical life transitions. DMHDDSAS staff have received training from the model developers to help shape the training and technical assistance process that new providers receive. Two teams are receiving funding through the Transitions to Community Living Initiative to focus on supporting individuals that are either leaving adult care homes or state psychiatric hospitals transition back into the community. We feel that with continued development and support for implementation, CTI can enhance our current State funded service array by adding an evidence based practice that specifically focuses on supporting individuals with SMI/SPMI through critical life transitions.
  Integrated Dual Disorders Treatment (IDDT): Integrated Care – Substance Use and Mental Illness

- Integrated Dual Disorders Treatment is not a stand-alone service in North Carolina. All ACT teams are required to have a Substance Use Specialist who has been trained in and practices from an IDDT approach, and further influences the practice of the whole team. IPS-SE practices principles also align with IDDT, specifically zero exclusion and rapid job search. DMHDDSAS is supporting improvement integration and implementation of IDDT practices by developing and facilitating the Mental Health/Substance Use 101 training (for free, open to all providers), coordinating technical assistance with Ric Kruszynski from Case Western Reserve, and including the provision of introductory motivational interviewing training through our

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contract with the Institute for Best Practices. DMHDDSAS is currently a certified ACEP contact hour provider, which allows us to offer free contact hours for trainings and encourage licensed clinicians to attend. We are hoping to explore expanding the dual licensure program to LPCs. This program is currently only available to individuals pursuing their MSW, and allows them to have met most of the criteria to become both an LCAS and LCSW. By expanding this opportunity to LPCs, we would increase the number of licensed staff in NC that are trained and qualified to work with individuals dealing with co-occurring mental health and substance use issues.

- **Peer Services**
DMHDDSAS is working to develop a State wide, State funded Peer Support service definition. We are also in the process of working with Medicaid to determine what steps can be made to add Peer Supports to the State Plan Amendment, which also would increase access to this valuable service across the state. We are extremely excited to be funding a pilot Peer Respite Program with MHBG funds. NC has been fortunate to collaborate with the Georgia Mental Health Consumer Network to find out more about the implementation and benefits of having Peer Operated Respites in our state. The pilot site, located in Asheville, will be the first of its type in NC. DMHDDSAS is working closely with Vaya (managing LME-MCO) and Sunrise Community for Recovery and Wellness (provider) to track implementation progress, costs, and outcomes and determine what is needed to add additional sites across the state. We continue to consult with our colleagues in Georgia for tips and feedback.

Transitions to Community Living Initiative (TCLI)

TCLI has provided the framework we are actively applying to our State funded Adult Mental Health Service Array. Our team routinely looks back not just to TCLI, but also to the Olmstead Act and the Americans with Disabilities Act to ensure what we plan and do aligns with our community integration mandate, viz., community based services and supports are available and vary in clinical intensity, services are infused with recovery focused practices that pull from psychiatric rehabilitation and other evidence based practices, and service providers are actively supporting individuals identify, engage in, and become active members of their community.

Mental Health Recovery

The Adult MH Team is identifying ways and practices that can bring recovery into the AMH service array. Some of our plans include: increasing DMHDDSAS staff knowledge on psychiatric rehabilitation so this practice can then influence our service delivery, identifying emerging best practices that focus on community involvement and integration, researching service models not yet used in NC for pilot consideration. Other division staff are working to develop and evolve a grass-roots mental health recovery movement statewide, grounded in both a statewide organization as well as a number of related local collaboratives – a hot topic at the recent 9th Annual NC "One Community in Recovery" Conference, November 8-10, 2017, sponsored by DMHDDSAS.

Older Adults

The Geriatric / Adult Specialty Team (GAST) program provides training to staff working with older adults living in the community. GAST began in 2003, focusing on long-term care facilities in response to the closing of NC's state psychiatric hospitals' gero-psych units. Over the years the program's mission has expanded to include caretaker training in such community settings as senior centers, day programs and psychosocial rehabilitation centers, and in conjunction with social services, law enforcement and first responders. Training is designed to help geriatric caretakers understand how mental illness, especially depression and anxiety, manifests in older adults. It

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especially focuses on how to recognize suicide thoughts, and substance use / misuse. GAST trainings and brochures routinely review how older adults can access mental health services through NC's LME-MCO network.

The NC Mental Health and Substance Use Aging Coalition was established five years ago. It now has over 300 members, many of whom are older adults. The Coalition provides advocacy and education to communities, and promotes evidence based practices for older adults.

Integrated Care

Behavioral Health and Primary Care

Integrated care became a focus of the state in 2006 with the establishment of the North Carolina Integrated, Collaborative, Accessible, Respectful, and Evidence-based (ICARE Partnership) that promoted a co-location of behavioral health and primary health care practitioners in one setting. Then Governor Beverly Perdue identified it as one of the priorities of her administration in 2009.

The NC Department of Health and Human Services has ongoing integrated care initiatives in several divisions, most prominently in the Office of Rural Health, Public Health, and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS). Three of the DMHDDSAS SAMHSA-funded projects – Screening, Brief Intervention, and Referral to Treatment (SBIRT), Medication-Assisted Treatment for Prescription Drug and Opioid Abuse (MAT-PDOA), and the Certified Behavioral Health Center (CCBHC) Planning Grant focused on the integration of primary and behavioral health care needs for adults with mental health, substance use, and co-occurring disorders.

Substance Use and Mental Health

Enhanced Services
- ACT – Substance Use Specialist, whole team practice of IDDT, monitoring of provision of co-occurring disorders treatment, Motivational Interviewing and interventions in line with stages of change
- IPS- practice principles align with best practices for SU, specifically zero exclusion and rapid job search
- Outpatient services
- Comprehensive Clinical Assessments are required to assess for substance use, and determine a diagnosis if clinically indicated
- Fidelity monitoring processes support IDDT practices

Training
- UNC Institute for Best Practices contract – how it supports integration
- Consultant, Ric Kruszynski, from Case Western Reserve provided 3 consultations/trainings on IDDT
- MINT trainer, Stacy Smith, providing free Intro to MI training with plans to expand training for more advanced MI
- Critical Time Intervention
- MH/SU 101 offered free to all service providers and community members
- Future endeavors: Cognitive Enhancement Therapy, Co-Occurring Disorders 101, making materials from Case Western available online for providers
- DMHDDSAS is a certified ACEP contact hour provider, this can increase attendance at trainings for licensed staff as we are able to provide free contact hours for in person trainings

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- Several universities in NC have programs in their Social Work departments where students can elect to take courses in substance use while completing their social work courses, and have met the educational requirements for their LCAS when they graduate. These programs increase the number of dually licensed master's level clinicians in NC.

<u>Employment</u>

- NC implemented IPS-SE in 2013, we now have roughly 36 teams across NC
- Per the current State funded IPS-SE service definition, an IPS-SE team is required to have on staff
  - An IPS-SE Team Lead (Qualified Professional)
  - An Employment Support Professional (Qualified Professional or Associate Professional)
  - An Employment Peer Mentor (Certified Peer Support Specialist)
- Employment Peer Mentors are required to complete the Employment Peer Mentoring training in addition to trainings required to become a Certified Peer Support Specialist
- In FY17-18, $237,857 in MHBG funds was allocated to the Institute for Best Practices at UNC-Chapel Hill's Center for Excellence in Community Mental Health. Through these funds and this contract, DMHDDSAS is able to increase its resources around training, technical assistance, and fidelity evaluations. The Institute employs 6 staff, regionally located, that are IPS-SE Consultants and Trainers. Each Consultant and Trainer is assigned 5 IPS-SE teams that they provide training and technical assistance to. The Institute also facilitates the IPS-SE 101 training, which is required for all IPS-SE staff per the State funded service definition.
- In FY17-18, through special funds designated for the Transitions to Community Living Initiative, DMHDDSAS allocated expansion funds to all IPS-SE teams scoring 100 or higher on their most recent fidelity evaluation. These funds are to be used to add 1-2 additional IPS-SE staff, which will allow IPS-SE teams to serve more individuals. Expanding this way will ensure that individuals receiving State funded IPS-SE services have access to quality IPS-SE.
- In FY17-18, through special funds designated for the Transitions to Community Living Initiative, DMHDDSAS will be posting RFAs for new IPS-SE teams to start in targeted, currently unserved areas of the state. DMHDDSAS will be reaching out to the corresponding LME-MCO, reviewing the identified locations where there are no IPS-SE teams, and partnering with the LME-MCO through the RFA selection process. DMHDDSAS staff will bring their subject matter expertise to the RFA development, review, and selection process.
- DMHDDSAS has been collecting outcome data through NC TOPPS on IPS-SE outcomes. The data set is currently incomplete, and we plan to improve compliance this coming year. However, the current data that has been submitted shows:
  - % of people working FT/PT at IPS-SE service initiation= 19% (205/1093)
  - % of people working FT/PT after 3 months of IPS-SE= 36% (285/788)
  - % of people working FT/PT after 6 months of IPS-SE= 40% (234/594)
  - % of people working FT/PT after 12 months of IPS-SE= 53% (120/226)
- 1,154 individuals responded to a question regarding rate of pay, and the data showed that:
  - 24% of individuals make above minimum wage
  - 7% of individuals make minimum wage
- 1,154 individuals responded to a question regarding benefits, and the data showed that:
  - 32% of individuals reported receiving some type of benefit through their employer. More specifically, of the 32%:
    - 33% received group insurance (health, dental, life, etc.)

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- 40% receive paid time off
- 5% receive a meal/retail discount

Housing

Homelessness

The PATH Program is located in Charlotte, Asheville, Greensboro and one will begin soon in Raleigh. The target population is those people with serious mental illness who are living in the street. Since 2005, PATH has used a team approach with a Certified Peer Specialist. The team also includes a QMHP and a Benefit Specialist implementing SOAR. People enrolled in PATH receive assistance in accessing mental health services through the LME-MCO. Teams receive the following training yearly: Trauma Informed Care, Person centered Thinking, and Recovery.

NC Oxford Houses *(Funding Source: SAPTBG, CURES, & STATE)*

- The partnership between NC DHHS-Division of MH/DD/SAS and Oxford House, Inc. began in 1991, and resulted in the development of the Revolving Loan Fund and the opening of the first two NC Oxford Houses (Durham & Asheville) for individuals in recovery.
- For FY18, the Division (DMH/DD/SAS) has contracted with Oxford House, Inc. using SAPTBG and State Funds to add to the number of Oxford House, recovery beds, mentor and to provide peer mentoring to the over 1,300 individuals living in a NC Oxford House. In addition, as part of NC's response to the opioid crisis, the Division has contracted with Oxford House, Inc. to add two new positions:
  - Re-Entry Coordinator Position – Transition and mentor individuals from incarceration, to re-enter the community into NC Oxford Houses.
  - Training and Education Coordinator Position – Conduct training sessions to targeted house members and NC Oxford House contract staff on the risk of opioid misuse, appropriate use of an FDA approved product for emergency care and other pertinent areas of need.

Some Facts about NC Oxford Houses include:
- Oxford Houses are democratically run recovery houses with 6 to 10 residents
- There are over 230 NC Oxford Houses, which equates to over 1,700 recovery beds
- They serve men, women and special populations i.e., veterans, persons re-entering from CJ system, students in recovery enrolled at targeted universities, women with children and men with children
- Residents have voting rights, hold offices and are expected to maintain their recovery
- Residents that are dispelled for not maintaining their recovery, can return to reapply to any Oxford House
- Residents share household expenses, i.e. rent and utilities
- Residents share household upkeep responsibilities
- Majority of the residents are employed and/or enrolled in school
- Many of the residents are active in their communities

LME-MCO Housing & Transition to Community Living Initiative (TCLI) Activities

Collaboration between NC Oxford House Outreach Staff & LME-MCO Housing Staff (*Funding Source: SAPTBG, State and MHBG*)
As part of the Division's efforts to increase awareness and usage of recovery beds for the Transition to Community Living Initiative, as well as to foster greater collaboration between our varied housing partners, NC Oxford House outreach staff were asked to notify LME-MCO housing staff of their plans to open new NC Oxford

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Houses. NC Oxford Houses, has played a major role in providing the much needed housing for persons in recovery in need of stable, safe, decent and affordable housing coupled with peer support.

LME-MCO Housing Staff Collaborating with Local and State Partners to Support DHHS-DMH/DD/SAS Housing Goals (*Funding Source: MHBG*)

The DHHS-DMH/DD/SAS (the Division) has had a long history of focusing on developing new housing opportunities and increasing access to existing housing. In 1998, the first dedicated housing staff were initially funded by the Division, and housed within some of the local "Area Programs" across our state. In 2007, the local housing staff played a major role with supporting the expansion of the Targeting Program. The Targeting Program (TP) was developed out of a partnership between the DHHS and the NC Housing Finance Agency, working in collaboration with key property owners, managers and service providers in which these TP rental units were:

- Designated for persons with a disability living with extremely low income. They are 10% (with some up to 20%) of units set-aside from rental apartments developed with Low Income Housing Tax Credits (all Housing Credit Properties are required to set aside at least 10%).
- To link individuals with disabilities who have extremely low income with permanent housing that is decent and affordable coupled with an array of available supports and services.
- Highly dependent on LME-MCOs to manage the adult mental health services array, to ensure that there was an adequate array of supports and services available to support persons living in TP units.
- Subsidized with Key Rental Assistance (state funds) that made these units affordable to persons living with disability income.

   In 2008, the largest expansion of funding to support previously unfunded housing positions was allocated to ensure that all of the Local Management Entities (LMEs) had at least one designated housing expert. Currently, there are no less than two dedicated housing coordination staff (housing experts) located at each of the (seven) LME-MCOs. The FY18 Contract between the Division and LME-MCOs contains some key designated housing activities which includes, but not limited to:
- Having a designated single point of contact (Housing Coordinator) at the LME-MCO shall be identified to coordinate all housing efforts and work closely with the other TCLI team members.
- Developing of housing opportunities for consumers via collaboration and partnerships
- Participating in quarterly meetings
- Collaborating with stakeholders to provide education and outreach to internal and external stakeholders, advocates, consumers, families and service providers in identifying, accessing and maintaining affordable housing, regarding the N.C. Landlord-Tenant and Fair Housing Laws, and negotiating reasonable accommodations.
- Developing positive working relationships with local public housing authorities (PHAs) and HUD Section 8/Housing Choice Voucher administering agencies to include PHAs in CoC and to improve access and increase the supply of these resources.
- Arranging site visits of newly opened NC Oxford Hoses, as made known within two months.

Transitions to Community Living Initiative (TCLI)

Integrated Community Living

LME/MCO must perform Diversion, In-Reach, and Transition activities for the population specified in the August 2012 Settlement Agreement between the State of North Carolina and the U.S. Department of Justice and according to the requirements of this section.

LME/MCO shall make all services in the TCLI benefit package included in the DMH/DD/SAS approved adult services array, including Peer Support Services, IPS-SE, and ACT, available to TCLI participants.

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In addition to the other general provisions of this Contract related to special populations, the following activities are required for individuals in the TLCI Benefit Plan, as specified by DHHS, and shall follow the requirements outlined in the DOJ Settlement Agreement and subsequent DHHS-approved, related plans.

Transition Planning

Transition Planning refers to the process of developing a person-centered transition plan to assist an individual in transitioning from an Adult Care Home or State hospital to a more integrated community living arrangement. This plan shall be used by the treatment provider to develop the person-centered recovery treatment plan. LME/MCOs shall ensure that all transition planning is person-centered and follows the guidelines set forth by DHHS in support of the DOJ Settlement Agreement.

Subject to available funding allocated to the LME/MCO for this purpose, LME/MCO shall hire or contract for in-reach and transition staff who meet one of the following qualifications:

- Care Coordinator
- Certified Peer Support Specialist (must be Certified Peer Support Specialists within six (6) months of being hired).
- Meet at least Qualified Professional (Mental Health/Substance Abuse) minimums for education and training.
- Transition staff roles/expectations:
- Assure that discharge/transition planning occurs timely and effectively
- Ensure the development of an effective, person-centered transition plan for the TCLI Population that includes all required elements for a successful transition.

Diversion

The LME/MCO will assign staff or contract with an adequate number of staff to account for the number of individuals covered under the population definitions/criteria to carry out the requirements of the DOJ Settlement related to diverting individuals from admission to licensed Adult Care Homes. The LME/MCO will produce for the DMH/DD/SAS their criteria and analysis that demonstrates adequate staffing levels. The LME/MCO will:

- Ensure that all individuals in the TCLI priority population process of diversion have the elements of community integration plans a Community Integration Plan (CIP) that meets requirements standards set by DHHS. LME/MCOs shall ensure that all CIPs meet DHHS quality standards and pass DHHS quality reviews.
- Review the CIPs to ensure they are completed with clear documentation that informed choice drove the individual's decision and the degree to which that decision has been implemented.
- Review the PASRR/PASD information to assess if individuals are eligible for Medicaid services, or State-funded services as available, are offered to individuals whether moving to the community or to an Adult Care Home.
- Connect individuals who have had CIP with services and supports that they are eligible for and determine if person is housing slot eligible.
- Assure that individuals who choose to be admitted to an ACH are referred for In-Reach, per the In-Reach requirements of the DOJ Settlement Agreement.

In-Reach

The LME/MCO must be able to demonstrate the sufficiency of staffing levels to perform In-Reach activities for the TCLI Population upon request by DMH/DD/SAS. In-Reach activities must include at a minimum the following and will be documented using the DHHS designed Transition to Community Living Database.

- Explaining fully the benefits and financial aspects of clinically-appropriate community-based integrated settings, including supported housing;
- Facilitating and accompanying individuals on visits to supported housing options/locations;
- Assessing Adult Care Homes residents' interest in supported housing;

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- Exploring and addressing the concerns of any of Adult Care Home residents who decline the opportunity to move to supported housing or who are ambivalent about moving to supported housing despite being qualified for such housing;
- Ensuring tenancy support transitions to housing are coordinated;
- Explore the individual's interest in finding employment, provide basic benefits counseling/information, and/or continuing their education;
- Reports made by LME/MCO staff or providers to the State, in accordance with State law, regarding concerns about rights of individuals, suspected potential abuse, neglect, or exploitation that arise during the in-reach and transition process; and
- Completing the DHHS In-Reach Tool for each individual.

Tenancy Support Services

Tenancy support services may be provided through ACT providers or through separate tenancy support providers. For those eligible for the TCLI benefit package, tenancy support services should be available at least twice per month for all individuals approved for a TCLI housing slot and not receiving tenancy support through ACT services.

TCLI Supportive Housing Efforts

The LME/MCO shall accomplish the milestones required under the Transitions to Community Living Initiative (TCLI) related to supportive housing for individuals in the TCLI Benefit Plan. A designated single point of contact (Housing Coordinator) at the LME/MCO shall be identified to coordinate all housing efforts and work closely with other TCLI team members. The LME/MCO shall fulfill the following general requirements:

- Educate and be a resource of support to TCLI consumers, families and service providers in identifying, accessing and maintaining affordable housing,
- Maintain minimum staffing levels through contracts or FTEs to ensure coordination of housing activities
- Ensure LME/MCO-specific housing goals as established annually by the DHHS are met. The Department and the LME/MCO will determine the number of slots it will fill for each year of the settlement agreement in accordance with NCGS §122C-20.10.

TCLI Housing

Development of Housing Opportunities for Consumers

The LME/MCO shall work in collaboration with other public agencies and DHHS' housing staff to increase the expansion of supported housing opportunities available to persons with mental illness, intellectual/developmental disabilities, and/or substance abuse disorders.

Quarterly Meetings

LME/MCO shall send a representative to the four quarterly meetings of Housing Specialists that are offered by the DMH/DD/SAS housing staff.

Education and Outreach

LME/MCO shall collaborate with appropriate stakeholders to provide education and outreach to internal and external stakeholders, advocates, consumers, families and service providers in identifying, accessing and maintaining affordable housing, regarding the N.C. Landlord-Tenant and Fair Housing laws, and on negotiating reasonable accommodations:

- Collaborate with the Transition Team, DHHS professionals and their vendors along with other stakeholders to identify and secure housing.
- Make available in multiple venues where Service Providers and other stakeholders convene, information to identify housing resources, expand knowledge of eligibility requirements for difference housing

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programs, how to access affordable housing resources, information to increase awareness of the Fair Housing Act, Americans with Disabilities Act, Landlord and Tenant Rights, barriers associated with Not In My Back Yard (NIMBY), and information to reduce stigma associated with mental illness, intellectual and developmental disabilities and substance use disorders.

- Attend at least one LME/MCO sponsored Provider's meeting within a year
- Offer to provide technical support to Service Providers and Consumers on accessing housing, and the process of making Reasonable Accommodation request.
- Available when needed to assure consumers are linked back appropriately to Service System when housing is at risk of becoming destabilized.

<u>**Collaborative Relationships**</u>

LME/MCO shall use best efforts to develop a positive working relationship with local public housing authorities (PHA) and HUD Section 8/Housing Choice Voucher administrating agencies to improve access and increase the supply of these resources:

- Regularly, strategically seek out means of establishing / nurturing partnerships with PHAs.
- Gain knowledge of, and seek out ways to support PHAs' supportive housing plan.
- Stay abreast of, and plan to attend at least one public meeting annually at a PHA in the catchment area.
- Work toward the ability to include PHAs in CoC, 10-Year Plan, and other local housing meetings.
- Work toward the ability to work collaboratively with PHA leadership to coordinate housing efforts, to educate on CoC HUD funded programs, discuss local Fair Housing issues, rental trends, etc.

LME/MCO shall also use best efforts to establish partnerships with other local, affordable housing and MH/DD/SAS advocates and stakeholders to improve access, increase the supply of resources for MH/DD/SAS consumers, and identify and secure housing and support service funding opportunities from private, city/county, state, and federal sources:

- Meet with property managers, and provide training opportunity for Landlords on supportive housing.
- Maintain regular communication with area housing agencies, and supportive housing advocates
- Gain knowledge of and strive to work collaboratively with local non-profits, developers, MH/DD/SAS stakeholders including NC Oxford House to encourage and support development of new supportive housing.
- Arrange a site visit of newly opened Oxford Houses as made known within two months.
- Gain knowledge of and strive to work collaboratively with local MH/DD/SAS advocates and stakeholders to encourage and support development of new supportive housing (participating jurisdiction, affordable housing providers, local Coalition, Center for Independent Living, etc.).
- Work with existing partnerships to establish additional resources (i.e. additional vouchers, housing opportunities, and programs).
- Identify potential housing development partners (i.e. Dept. of Social Services, city officials, faith community, public housing agencies, jail, prison, psychiatric hospitals, mental health, substance abuse, Intellectual Developmental Disability professionals and advocates).
- Strive to enhance working knowledge of funding sources and how to successfully secure and utilize to increase the supply of permanent supportive housing.
- Offer to provide technical assistance and support to identified agencies applying for state and federal funding opportunities (i.e. justification of need, providing data and information as it relates to available support services) as resources allow.

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Performance Expectations

TCLI Special Healthcare Population

Special reporting is required to measure progress in the Transitions to Community Living Initiative. The LME/MCO must track all services received by individuals that fall under any of these characteristics of the TCLI benefit plan population:

- Individuals with SMI who reside in an adult care home determined by the State to be an IMD;
- Individuals with SPMI who are residing in ACHs licensed for at least 50 beds and in which 25% or more of the resident population has a mental illness;
- Individuals with SPMI who are residing in ACHs licensed for between 20-49 beds in which 40% or more of the resident population has a mental illness;
- Individuals with SPMI who are or will be discharged from a State Psychiatric Hospital and who are homeless or have unstable housing;
- Individuals diverted from entry into ACHs pursuant to the pre-admission screening and diversion process;
- Individuals provided and referred to supported employment (data must be reviewed and validated by LME/MCO);
- Individuals in the In-Reach process; and
- Individuals in the TCLI Benefit Package.

Additional reporting may be required by the August 2012 USDOJ Settlement Agreement and subsequent monitoring of progress, and these additional reporting requirements will be negotiated between the parties as an amendment to this Contract. Complete data is entered into the TCLI reporting system by the 10th of each month for the previous month's information.

Transitions to Community Living Initiative Measures

TCLI Housing Goals
Measure: The percent of the LME/MCO's monthly housing slots filled
Source: TCLI Subsidy Administrator Report
Benchmark: 100% of the monthly total of the annual requirement

IPS-Supported Employment Goals
Measure: The percent of the LME/MCO's monthly number of required individuals served by fidelity IPS-SE providers
Source: LME/MCO Self-Report (DMH/DD/SAS validated)

Community-Based Mental Health Services in Place Prior to Transition
Measure: The percent of persons who transitioned to supportive community housing with tenancy support services in place 30 days prior to transition
Source: TCLI Subsidy Administrator Report and Claims/Encounters

Transition Within 90 days
Measure: The percent of persons who transitioned to supportive housing within 90 days of assignment to a transition team
Source: TCLI Subsidy Administrator Report

Timely Quality of Life Survey Completion
Measure: The percent of Quality of Life surveys completed before individuals' transition dates or within 30 calendar days before or after 11- and 24-month anniversaries in supportive housing
Source: TCLI Subsidy Administrator Report and participant Quality of Life Surveys submitted to DHHS.

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Benchmarks and Penalties

Beginning January 1, 2018, the following measures shall have a performance standard and corresponding penalty for each standard not met. Any month LME/MCO performance is below the performance standard, LME/MCO shall submit to DMH/DD/SAS and implement a corrective action plan (CAP) within 30 days. If the LME/MCO does not meet the performance standard for the next three (3) consecutive months following the implementation of the CAP, the LME/MCO will incur a penalty in the fourth month and each month following when the performance standard is not met. Penalties shall continue until LME/MCO meets the performance standard. LME/MCO shall be subject to a separate penalty for each standard not met.

Number of Individuals transitioned during month into supportive housing	The number is dependent on the individual LME/MCO monthly targets.	$50,000 maximum The penalty will be assessed based on a tiered percentage of persons placed.

Military and Veterans Programming Initiatives in NC Using MHBG Funds

Founded by clinical Health Professionals in 2006 as the *Governor's Focus Group on Service members Veterans, and their Families*, in partnership with the Governor's Institute on Substance Abuse, it is known today as the **GOVERNOR'S WORKING GROUP on Veterans, Service members and their Families** (GWG). The GWG has grown to become a nationally recognized forum, which hosts a monthly meeting, newsletter, and website (http://ncgwg.org), as well as a YouTube Channel (https://www.youtube.com/watch?v=p2CwZHXzho4&feature=youtu.be). This real-time referral and collaboration network cuts red tape—linking decision makers, service providers, and military members (current and former) and their families together in a best-practices sharing environment.

Charged with facilitating collaboration and coordination among ALL Federal, State, Local, and Non-Profit partners who work with North Carolina's nearly 740,000 Veterans and their families, monthly sessions highlight:
• Health and Wellness, including Behavioral Health
• Transitional Services
• Veterans Benefits and Claims
• Community-based Services and Supports
• Housing Resources
• Education and GI Bill
• Job Creation and Workforce Enrichment
• Legal and Financial Services

Functioning collaborations fostered at GWG sessions include:
• NC STRIVE (Student Transition Resources Initiative for Veterans Education)
      4 Regional Higher Education Conferences in April 2018
         http://ncgwg.org/nc-strive/
• Operation HOME: Ending Veterans Homelessness Task Force
      http://ncgwg.org/operation-home/
• Women Veterans Summit and Expo
         http://women.nc4vets.com/
• NC Practice Improvement Collaborative (NC PIC) to Reduce Veteran Suicide
         http://ncgwg.org/nc-officials-work-to-end-states-high-veteran-suicide-rate/
         http://ncgwg.org/5-veteran-suicide/

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The Governor's Working Group Leadership:
- **Larry Hall, Chairman,** Secretary, NC Dept of Military and Veterans Affairs
- **Jason Vogler, Vice-Chair,** Director, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, NC Dept of Health and Human Services
- **Napoleon Wallace, Vice-Chair,** Deputy Secretary, NC Dept of Commerce
- **Mark Bilosz, Vice-Chair,** Director, Veterans Benefits Administration, Winston-Salem Regional Office, US Dept of Veterans Affairs
- **Joseph P. Edger, Vice-Chair,** Deputy Network Director (VISN-6), VA Mid-Atlantic Health Care Network, US Dept of Veterans Affairs
- **James Prosser, Vice-Chair,** Director of Veterans Affairs, NC Dept of Military and Veterans Affairs

Deaf Services

NC DMHDDSAS has been providing specialized services to Deaf, Hard of Hearing and Deaf-Blind individuals since 1992. These services stem from one of the earliest ADA complaints filed in NC, alleging Deaf individuals were not receiving appropriate care in the public mental health system. While the original complaint was resolved long ago, the state continues to show a commitment to providing language accessible and culturally competent MH/SUD services to this population.

In SFY17, the state started contracting directly with RHA Behavioral Health to provide MH/SUD services to this population across the state. This direct service contract allows the Division to achieve budget efficiencies and ensure services are provided evenly across the state. Prior to SFY17, these services were managed and contracted out through the LME-MCOs.

RHA employs 10 full time licensed clinicians (LCSWs, licensed counselors, licensed psychologists), 6 Outreach Consultants (3 are certified Peer Support Specialists), a program director, business manager and a part-time administrative assistant. All staff are sign language fluent as measured by the Sign Language Proficiency Interview (SLPI). About 90% of contract staff are deaf. Copies of position descriptions are available electronically.

DMHDDSAS hosts a Deaf Mental Health Advisory Council (MHAC) to advise the Division on services and provide feedback related to programming. The 13-member Council meets four times per year in Raleigh. Most of the Council members are deaf and some identify as being in recovery. Further, the Division hosts three Community Listening Sessions each year at selected sites across the state to obtain feedback about programming and services.

Peer Support

Peer Support was added to the service array in SFY17. During the Spring of 2017, three staff members obtained credentials. RHA is working now with UNC-Chapel Hill to develop their own peer support training package that will allow them to train other Peer Support Specialists who are fluent in sign language. Staff were unable to begin providing Peer Support in SFY17, but RHA is working to implement the provision of this service in SFY18.

Funding

State Appropriations: $1,156,629
MHBG: $457,558
Total: $1,614,187

Service Array

Most services are provided in the community. RHA utilizes secure telephone conferencing to provide Telepsychiatry and therapy services. While this technology has reduced travel, RHA staff still travel frequently and drove @225,000 miles in SFY17. There are 4 large service categories in the contract:

Outpatient Behavioral Health
Outpatient behavioral health services are psychiatric and biopsychosocial assessment, medication management, individual, group, and family therapies, psychotherapy for crisis, and psychological testing for eligible beneficiaries.

These services are intended to determine a beneficiary's treatment needs, and to provide the necessary treatment. Services focus on reducing psychiatric and behavioral symptoms in order to improve the beneficiary's functioning in familial, social, educational, or occupational life domains.

Outpatient behavioral health services are available to eligible beneficiaries and often involve the participation of family members, significant others, and legally responsible person(s) as applicable, unless contraindicated.

Based on collaboration between the practitioner and beneficiary, and others as needed, the beneficiary's needs and references determine the treatment goals, frequency and duration of services, as well as measurable and desirable outcomes.

Outpatient Behavioral Health Services may occur face to face or via professional video conferencing equipment as professional practice standards dictate.

Peer Support
Peer support services are new to the service array. These services are provided by certified Peer Support Specialists who are sign language fluent.

MH/SUD Peer Support services are structured and scheduled activities for adults age 18 and older with MH/SA disability. Peer Support services are an individualized, recovery focused approach that promotes the development of wellness self - management, personal recovery, natural supports, coping skills, and self - advocacy skills and development of independent living skills for housing, employment and full community inclusion.

Interventions for Peer Support services are evidence - based per the Consumer Operated Services Evidence Based Practices Toolkit (SAMHSA, 2011) and are guided by a variety of research publication and principles identified by the Recovery Community Services Programs (SAMHSA, 2009).

Peer Support services align with the Recovery Oriented Systems of Care (ROSC) framework model and are a vital component necessary to promote individual resiliency.

Peer Support services may be provided in any location except for the Peer Support staff's home. A fundamental feature of Peer Support is that the services are provided in the natural environment as much as possible. These services are non-clinical in nature, and are aimed at increasing support to the individual being served, and increase the individual's "recovery capital".

Collateral contacts and telephone calls to the individual are billable; however, 80% of contacts must be face-to-face with the individual receiving services. Face-to-face contacts may be subject to reasonable accommodations that are HIPAA compliant, and are not intended to replace or decrease the frequency of face-to-face contact.

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Peer Support Individual may not exceed 15 recipients per Peer Support staff. Peer Support Group may not exceed 6 recipients per Peer Support staff.

Mental Health/Substance Use Disorder Outreach and Support

This service consists of providing the assistance necessary to help the recipient achieve and maintain sobriety and recovery. The service is designed to help the recipient meet treatment, financial, social, and independent living goals. The worker provides coordination of movement across levels of care, directly to the recipient and his/her family. The worker assists other MH/SUD professionals with discharge planning and community re-entry following hospitalization, residential services and/or other levels of care. Service activities consist of a variety of interventions: identification and intervention to address barriers that impede the development of skills necessary for independent functioning in the community; family psychoeducation, and one-on-one interventions with the recipient to develop interpersonal and community coping skills. Outreach may assist the recipient with adaptations needed at home, school, and work; therapeutic mentoring; symptom monitoring; and monitoring medications. MH/SUD Outreach and Support includes assisting with the linking or integrating of needed services with other providers as well as assessment and reassessment of the recipient's need for services. Outreach may also assist the recipient with accessing benefits and services

Mental Health/Substance Use Disorder Consultation

This is a service provided to mental health, human service, and community planning/development organizations or to individual practitioners in other agencies or organizations. Consultation *may* be client specific and focus on individual client needs. Case Consultation is designed to assist in the development of insights and skills necessary to increase the quality of care available in the service delivery system. Additionally, this service is designed to assist organizations and/or practitioners to improve the service environment within their service delivery system.

Mental Health/Substance Use Disorder Education

This service is designed to inform and teach patients, families, schools, businesses, churches, industries, civic and other community groups about the nature of mental health, developmental disabilities, and substance use disorders, and about available community resources. It also serves to improve the social functioning of recipients by increasing awareness of human behavior and providing alternative cognitive/behavioral responses to life's problems.

Outpatient Behavioral Health and Peer Support Services are Medicaid billable, Outreach & Support and Consultation & Education are not.

Data Summary

DMHDDSAS maintains a statewide, web-based database for tracking services. Below is summary of statewide data from SFY13 to SFY17. Comprehensive data reports are available electronically.

SFY13

Number of People Served	Comprehensive Clinical Assessment (Hours)	Clinical Assessment (Hours)	MH/SUD Therapy (Hours)	Outreach, Support (Hours)	Consultation, Education (Hours)	Travel (Hours)	Psychological Assessment (Hours)
803	142	73	3576	4351	3227	3816	26

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SFY14

Number of People Served	Comprehensive Clinical Assessment (Hours)	Clinical Assessment (Hours)	MH/SUD Therapy (Hours)	Outreach, Support (Hours)	Consultation, Education (Hours)	Travel (Hours)	Psychological Assessment (Hours)
1049	190	71	2828	6066	2458	4041	29

SFY15

Number of People Served	Comprehensive Clinical Assessment (Hours)	Clinical Assessment (Hours)	MH/SUD Therapy (Hours)	Outreach, Support (Hours)	Consultation, Education (Hours)	Travel (Hours)	Psychological Assessment (Hours)
627*	207	29	2630	6247	1410	3309	71

*Number of People Served calculation change – persons must be registered and enrolled in the Alpha data management system at the "home" LME-MCO

SFY16

Number of People Served	Comprehensive Clinical Assessment (Hours)	Clinical Assessment (Hours)	MH/SUD Therapy (Hours)	Outreach, Support (Hours)	Consultation, Education (Hours)	Travel (Hours)	Psychological Assessment (Hours)
522*	209	47	2988	5267	552	3080	30

SFY17

Number of People Served	Outpatient Behavioral Health** (Hours)	Outreach, Support (Hours)	Consultation, Education (Hours)	Travel (Hours)	Psychological Assessment (Hours)	Contract Psychiatry (Hours)	Peer Support (Hours)
524	3225	5663	660	2591	85	107	0

** Therapy, PCP, diagnostic assessment

Sources: Service descriptions are taken from NC Division of Medical Assistance Behavioral Health Coverage Policies, located at https://dma.ncdhhs.gov/behavioral-health-clinical-coverage-policies.

Service data is taken from the DMH Deaf Services Clinician database. It is located at http://www.ncdmh.net/clinician_asp/Login.aspx.

Adult Criminal Justice

Justice Systems Team

The Justice Systems Team was developed in 2001 following our recognition that our consumers of MH/DD/SA services were frequently also involved with the criminal justice or juvenile justice systems, and that effectively assisting those individuals requires dedicated staff working in close coordination with those systems. Through establishment of the Justice System's Team, we've strengthened our partnership with the Dept. of Public Safety, including our prisons and community corrections, and our partnership with law enforcement agencies throughout the state. Functions and programs housed within the Justice Systems Team include TASC, jail

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diversion program management, Crisis Intervention Team (CIT) coordinator at the state level, DWI, Drug Treatment Schools, management of the controlled substance reporting system, our Mental Health First Aid initiative, and prison reviews of treatment programs for our consumers.

Community Behavioral Health Paramedicine (CBHP) Pilot Program

Community Behavioral Health Paramedics are Emergency Medical Services (EMS) staff who are specially trained to intervene with patients experiencing behavioral health crises. The CBHP program provides incentives for the participating EMS to either treat on-scene or route those patients not needing medical treatment to lower cost alternatives to hospital emergency departments (EDs).   State funding was provided to twelve EMS agencies that collaborated with LME-MCOs and local providers to implement this program model.

CBHP Programmatic Goals:
1. Diverting individuals in behavioral health crisis to specialized behavioral health services, rather than a hospital ED, when appropriate, and
2. Ensuring individuals in behavioral health crisis, once fully evaluated, are referred to the least intrusive care that meets their treatment needs, thereby avoiding EMTALA rules on hospitals that restrict involuntary commitment (IVC) and transfer to any facility but those providing the highest and costliest level of care (inpatient).
3. Reducing ED usage and inpatient care, to reduce the cost of behavioral health crises.

An evaluation of this program determined it was effective in meeting all these goals, without compromising patient care or safety. DMA will be seeking to expand this pilot program through a state plan amendment making it a Medicaid reimbursable service, if permitted to do so by CMS.
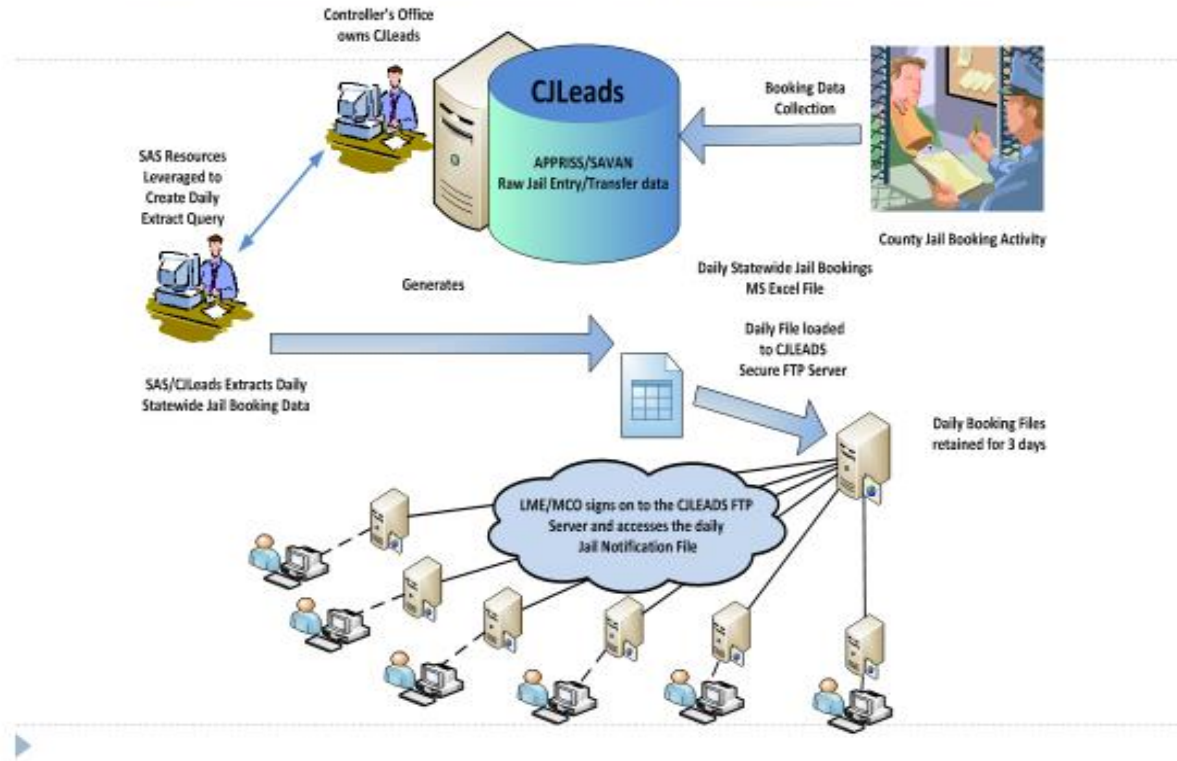

CJ LEADS

Every year, thousands of our consumers end up in our county's jails due to behaviors resulting from symptoms of their mental illness – usually for minor crimes that pose little threat to public safety. Often the jails are not aware of the detainee's mental illness, or if aware, they may not always contact the LME-MCO regarding the consumer's medical needs. To more effectively and efficiently identify these consumers in jail, the DMH/DD/SAS and the NC Office of the Controller recently entered into an agreement that will enable DMH/DD/SAS and the LME-MCOs to obtain the Criminal Justice Law Enforcement Automated Data Services (CJ LEADS) data regarding persons booked into jails throughout our state.

Obtaining CJ LEADS data eliminates the need for LME-MCO staff to manually check the daily jail booking logs for consumers.   Each working day, an Excel file is made available to LME-MCOs providing them with data that can be sorted, filtered, and matched to their roster of consumers to help identify persons in your LME-MCO that have been booked into jail, along with information that will enable the LME-MCO to locate these consumers and contact the jail where they are detained. Using these data, your LME-MCO staff can quickly identify your consumers who've been booked into jail so that they can:
- Collaborate with the jail regarding the treatment needs of their consumers,
- Participate in planning for their release from jail, and
- Advocate for the diversion of these consumers from jail to treatment in the community, when appropriate.

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There is a one-way flow of information from the jails to the LME-MCOs that includes no transmission of confidential or health-protected information. There will be no disclosure of any information about consumers back to CJ LEADS or our criminal justice partners.

The full potential of CJ LEADS has yet to be reached, as only one LME-MCO (Alliance) has developed an effective interface between the CJ LEADS database and the database of LME-MCO consumers. But the Alliance / CJ LEADS system may serve as a model for others in NC.

Crisis Intervention Teams

Crisis Intervention Teams (CITs) are pre-booking jail diversion programs that aim to provide people in mental health crisis the care they need instead of incarceration. Mental health professionals have established CIT programs to provide law enforcement with the skills they need to deal with someone in a mental health crisis in this 40-hour training program. CIT programs also emphasize law enforcement and mental health systems working collaboratively to develop a network of services to support people in crisis. CIT helps to:

- Reduce officer and consumer injuries
- Reduce the arrest of people with mental illness
- Increase referrals to treatment for people with mental illness

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NC law enforcement officers CIT certified	9,536
Participating NC law enforcement agencies	393
Tele-communicators (dispatchers) CIT trained	970
Private security officers CIT trained	163
Fire fighters, EMTs & paramedics CIT trained	996
Others[1] who have received CIT training	788

An additional 1,343 CIT officers became CIT certified in calendar year 2016, resulting in a 16% increase from the previous year. An additional 24 law enforcement agencies began participating in a CIT program in North Carolina in 2016 - a 7% increase from the previous year.

There are approximately 13,063 police officers and 8,080 sheriff's deputies in North Carolina, for a total of 21,143 law enforcement officers in the state[2]. Based on these statistics, the proportion of all North Carolina law enforcement officers that were CIT certified by January 1, 2017 was more than 45%.

Although great progress has been made in disseminating CIT throughout the state, much remains to be done. Penetration of CIT in law enforcement agencies remains uneven; with some agencies having all their officers CIT-trained, many having sufficient numbers of CIT trained officers, and other agencies having few or no CIT trained officers. There are no CIT officers in 6 of 100 counties in North Carolina. Also, many agencies participating in CIT have yet to establish protocols, implement procedures, or provide training to tele-communicators to assure that CIT officers are dispatched on all "mental disturbance" calls. Furthermore, the ability of local mental health systems to provide a drop off capacity and a quick turnaround for law enforcement varies throughout the state, though recent funding of Behavioral Health Urgent Care Centers and Facility-Based Crisis Centers have expanded this capacity. We expect North Carolina Crisis Intervention Teams will continue to expand CIT training to many more officers and other first responders in 2017.

Expansion of Mental Health Curriculum of the Basic Law Enforcement Training

People with mental health crises comprise at least 10% of all calls to which law enforcement officers respond. However, only about 1% (8 hours) of the 640 hours of basic law enforcement training that officers receive in North Carolina concerns dealing with people with mental illness.

Division of MH/DD/SAS Justice Systems team staff worked with the NC Justice Academy to revise and expand the basis training that law enforcement officers in NC receive on mental illness from the current eight (8) hours to a total of twenty-four (24) hours of instruction, to include auditory hallucination simulation exercises, practical skills training in de-escalating people in crisis, and instruction on topics such as Post-traumatic Stress Disorder (PTSD) that were unable to be covered in the eight hour curriculum. The-24-hour curriculum is being piloted in five training sites in NC, and will be rolled out state-wide in the spring of 2018.

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[1] Others include magistrates, probation officers, NC State Bureau of Investigation (SBI) officers, National Park Service officers, community college staff, department of social services staff, hospital staff, peer specialists, domestic violence shelter staff, victims assistance staff, LME-MCO board members, animal control officers, provost marshals, officers from police departments in neighboring states, and military police from the following bases: Ft. Bragg, Camp LeJeune, Pope Air Force Base, and Seymour Johnson Air Force Base.

[2] Statistics obtained in 2015 from the NC Dept. of Justice, Training and Standards Division, and include only full time, sworn officers and deputies.

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Stepping Up Initiative in North Carolina

A national movement led by the National Association of Counties, the Council of State Governments, and the American Psychiatric Foundation, the Stepping Up Initiative aims to reduce the numbers of persons with mental illness who are inappropriately incarcerated in jails across our country. In North Carolina, county leaders are partnering with NC Division of MH/DD/SAS, the NC Association of County Commissioners, , NC Psychiatric Association, and others to find ways to end the cycle of repeated incarcerations of people with mental illness in NC. At least 44 North Carolina counties have passed resolutions joining the Stepping Up Initiative and supporting its goals.

The Division of MH/DD/SAS has supported Stepping Up in NC through the provision of technical assistance to individual counties, through state-wide networking conference calls, through webinars provided by DMH/DD/SAS staff, and through a state Stepping Up conference event to which we brought nationally recognized experts on these issues, and was attended by more than 200 individuals, including many county commissioners, sheriffs, police executives, and others.

Treatment Assessment Screening Center (TASC)

The mission of TASC in North Carolina is to provide leadership and guidance for innovative treatment and recovery supports that result in opportunities for justice-involved individuals with behavioral health needs to achieve healthy and productive lives with their families and communities in our state. TASC bridges justice and treatment systems by linking treatment and justice goals of reduced drug use and criminal activity. Objectively balancing public safety and public health, the TASC care management model reduces recidivism and improves justice, treatment and individual outcomes. TASC is organized into four regions which reflect the state's four judicial divisions, consistent with the unified court and statewide probation systems, and is available in all 100 North Carolina counties. Services include: screening and assessment of an offender's need for substance abuse or mental health services; treatment matching to ensure that the offender receives the correct level and type of care; referral and placement with appropriate service providers, care management through individualized service planning, coordination and monitoring to ensure compliance with criminal justice conditions, progress in treatment and recovery supports. Through access to an array of services, TASC prepares probationers, parolees and post-releases for a healthy and safe return to their communities.

Other Initiatives: Support for jail diversion initiatives, including five mental health courts in North Carolina.

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CHILD/YOUTH MENTAL HEALTH

North Carolina's System of Care for Children, Adolescents, Young Adults, and their Families

Children's Services

NC DMHDDSAS believes children and families are resilient and resiliency should be fostered and supported in order to promote increased social-emotional health, wellness and quality of life by receiving the appropriate evidence-based, culturally and linguistically competent screening, assessment, and treatment services tailored to the individual/family at the appropriate time.

NC uses the following foundations as it continues to build and expand its System of Care to serve children, youth, and young adults with SED and their families:
- Timely access to quality, evidenced-based, and culturally responsive array of services
- Care coordination to meet the needs of children with complex needs and their families
- Family and youth driven care, family and youth voice in governance structures, and family access to family and youth peer support
- Collaboration across agencies to meet the needs of youth with complex needs

The first three bullets will be discussed below but here are a few high highlights on DMHDDSAS' efforts to enhance collaboration with system partners through its involvement and partnerships in wide-ranging efforts.

Child Welfare

Project Broadcast: This project focuses on improving trauma informed care—screening, assessment, and treatment for children-- and culture change and support for involved departments of social services. DMHDDSAS was engaged in steering committee and in planning summits for LME-MCO leadership.

Bridging Local Systems: NC Institute of Medicine, LME-MCOS, and local departments of social service met over a year to develop protocols to improve communication.

Child Welfare Transformation Council: New legislation calls for state cross system council to address issues in child welfare. DMHDDSAS will be a participant.

Child Welfare Strategic Planning: DMHDDSAS staff participated in the development of the Division of Social Services strategic plan and its Performance Improvement Plan following a federal review.

Juvenile Justice

Juvenile Justice Substance Abuse Mental Health Partnerships (JJSAMHPs) are local teams across NC working together to deliver effective, family-centered services and supports for Juvenile Justice involved youth with substance use, mental health challenges, or facing issues in both areas. These teams consist of three (3) parts, LME-MCO representatives, Juvenile Justice Court Counselor Chiefs, and local providers, and require an organized person-centered system that operates under system of care principles. Currently there are 20 teams across the state. Teams focus their work around the five (5) domains of JJSAMHP; which include screening/referral, assessment, engagement, Evidence Based Treatment, and Recovery oriented systems of care (beyond treatment).

State Level -There is a Juvenile Justice Behavioral Health State Team consisting of representation from DMHDDSAS, DPI (public instruction), DSS, and JJ that meets to address needs for state and local partners.

Raise the Age: As NC works to enact legislation to raise its juvenile age to 18 years, DMHDDSAS will continue is collaboration with the Department of Public Safety to provide community-based and evidenced based services for youth with behavioral health concerns so they do not travel deeper into the juvenile justice or adult correction systems.

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Department of Public Instruction

Education in Psychiatric Residential Treatment Facilities: DMHDDSAS and the Department of Public Instruction partner to ensure the educational needs of youth in PRTFs are addressed. Funded and legislated by General Assembly (Part 4 of Article 6 of Chapter 122C of the General Statutes). DMHDDSAS and DPI staff develop contracts for education within PRTFs, monitor through joint site visits, and provide training and technical assistance on education requirements including transitions to community schools.

School Based Mental Health Policy: DMHDDSAS staff participated in work groups to develop new school based mental health policy that requires local school districts to develop plans for school based mental health access and referrals.

Other Cross System Collaborative Efforts

The North Carolina State Collaborative for Children, Youth, and Families, through a System of Care framework, provides a forum for collaboration, advocacy and action among families, public and private child and family serving agencies and community partners to improve outcomes for all children, youth and families. Multiple DMHDDSAS staff members participate in the state collaborative and its committees. One committee of the state collaborative provides governance for NC's System of Care Expansion Grant.

Cross System Work Group is a DMHDDSAS sponsored work group of state agency and family representation who are developing plans for use of shared data, a trauma informed state, considering how local collaboratives can increase communication and effectiveness, and exploring workforce issues that affect the workforce of all the agencies who work with youth with behavioral health challenges.

State Support for Local Community Collaboratives: North Carolina supports local community collaboratives through funding for System of Care Coordinators housed at LME-MCOs and for a statewide System of care Coordinator who supports the work of the System of Care Coordinators. The System of Care Coordinators staff the community collaboratives which work to address service barriers, identify system gaps, and develop cross system training plans.

In November 2016 the count of Community Collaboratives was:

73 SOC Community Collaboratives in North Carolina

64 single county Collaboratives

9 Multi-county Collaboratives

Opportunities-- DMHDDSAS will focus on the following opportunities to strengthen cross system collaboration:
- NC Medicaid Transformation: Focus on Integrated Care
- Raise the Age
- Child Welfare Transformation Council
- Build on Governors' Task Force Recommendation for Tiered Case Management/Care Coordination Pilots focused on youth in the child welfare and juvenile justice systems
- School Based Mental Health Policy
- Continue to work closely with Division of Medical Assistance (DMA) to improve service array.

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Domain 1: Access to Care. Timely access to a quality, evidence-based, culturally responsive array of services is critical to supporting NC's youth with SED.
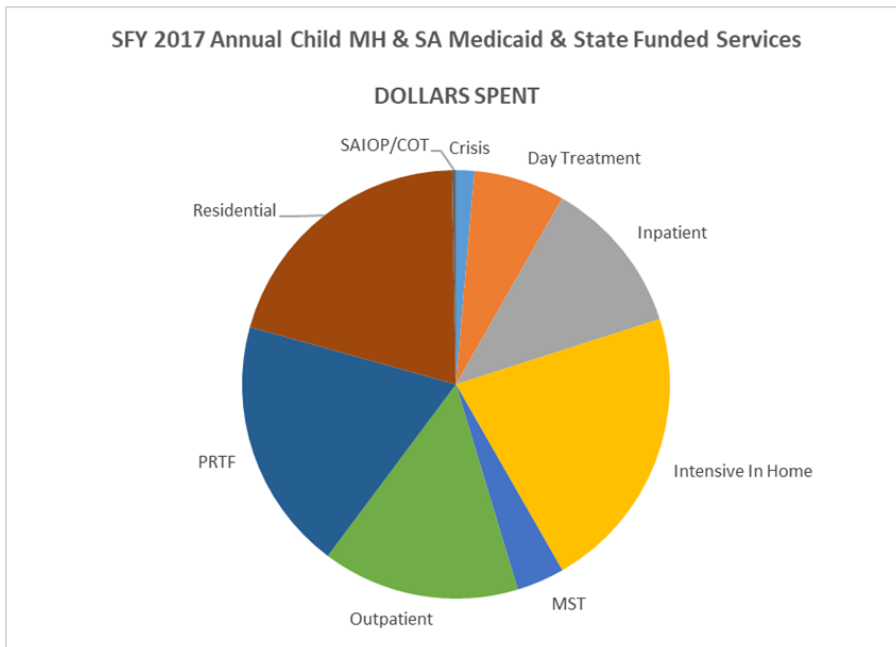
Here is a graphic of NC's service continuum for children.
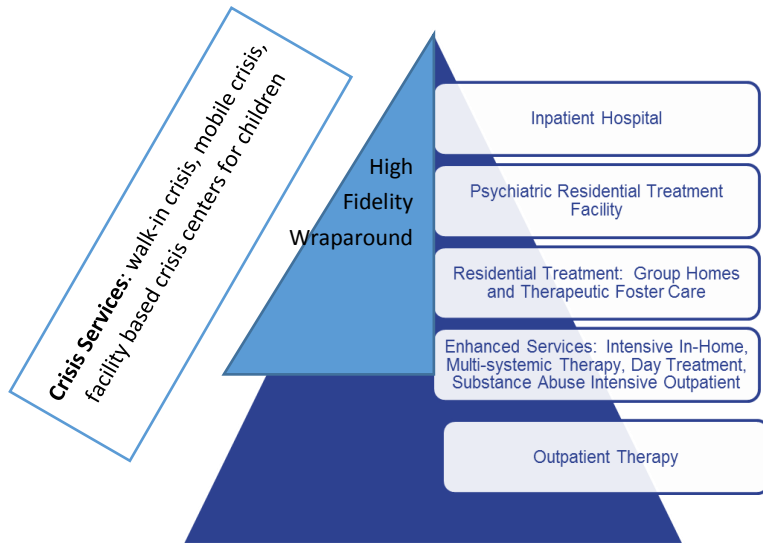
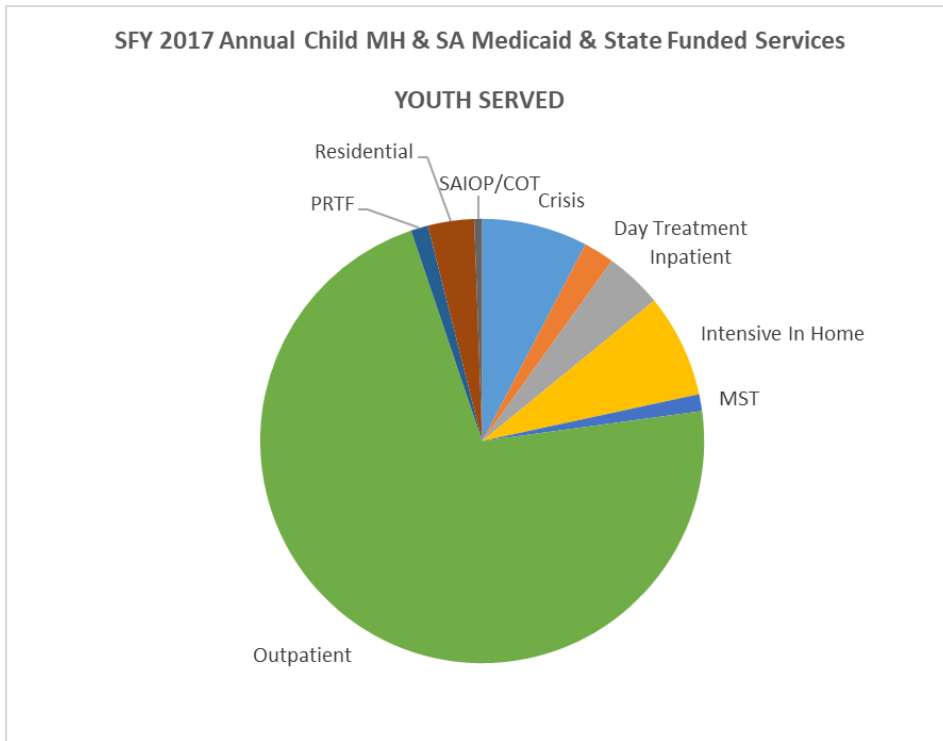

Child Community Services Continuum in NC includes:

- Outpatient Therapy
- Outpatient Therapy Plus (some LME-MCOs)
- Day Treatment
- SA Intensive Outpatient
- Intensive In-Home Services
- Multisystemic Therapy

Below you can see dollars spent and youth served in SFY 2017 for Medicaid and State Funded Services

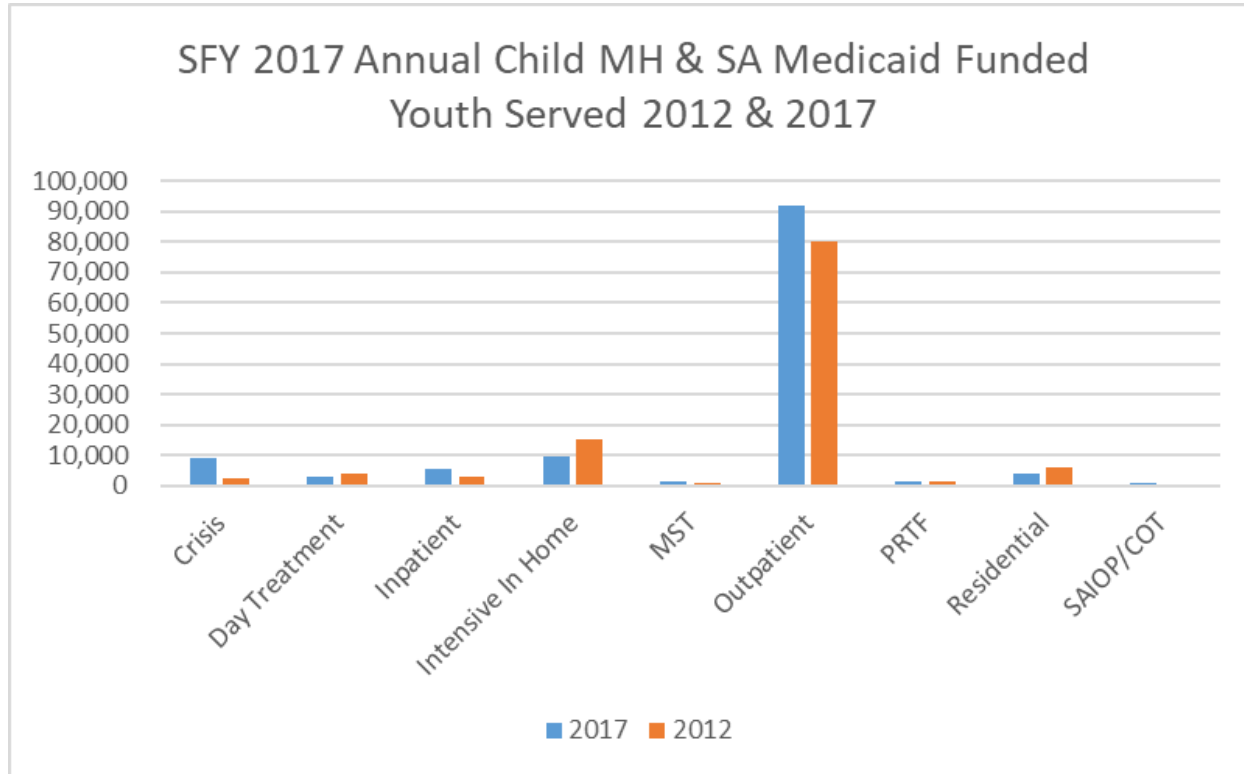SFY 2017 Annual Child MH & SA Medicaid & State Funded Services

DOLLARS SPENT

22

SFY 2017 Annual Child MH & SA Medicaid & State Funded Services

YOUTH SERVED

Here is a comparison for child services for SFY 2012 and 2017.

State Funded Services

23
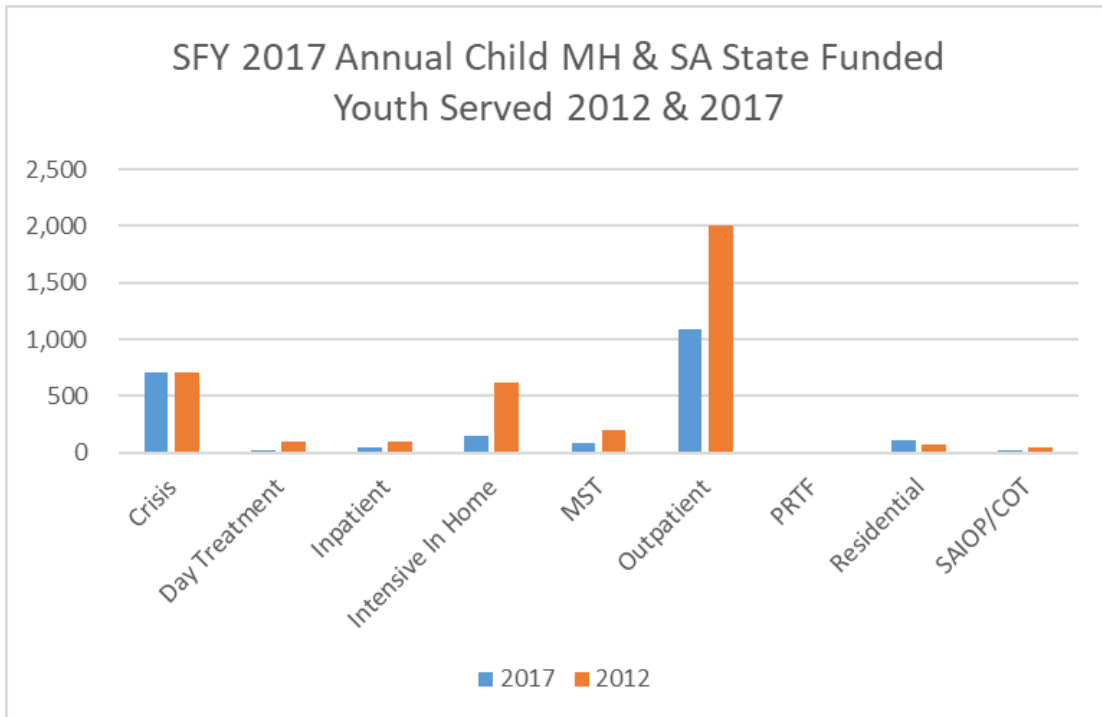
Medicaid Funded Services

SFY 2017 Annual Child MH & SA Medicaid Funded Youth Served 2012 & 2017

Care Coordination is critical for youth with complex needs. This is an outline of North Carolina's efforts to enhance care coordination for children:
- Care Coordination is available within the LME-MCOs
- Case Management is within service definitions for intensive in-home services, multi-systemic therapy, and day treatment
- Pilots for High Fidelity Wraparound: NC has four current sites of high fidelity wraparound with its System of Care Expansion Grant. Evaluation for the grant is based on data collected through the NOMS. Analysis is conducted quarterly and reported to the state level implementation team and the four sites for continuous quality management.
- Pilots of Tiered Case Management utilizing funds approved by the General Assembly based on the Governor's Task Force on Mental Health and Substance Use Disorders. This pilot is exploring three tiers of care coordination/case management for youth involved with child welfare and juvenile justice. These tiers are:

 --- LME-MCO care coordination + family navigator

-- Target case management

-- High Fidelity Wraparound
- Project to identify and provide care coordination to youth with complex needs who are dually diagnosed with mental health and intellectual/developmental disabilities. LME-MCO are identifying and providing the care coordination.

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A specialty care coordination and skill building service for youth aging out of foster care is LifeSet. LifeSet is jointly funded by its provider, Youth Villages, and the General Assembly.

Here is a map of LifeSet coverage:
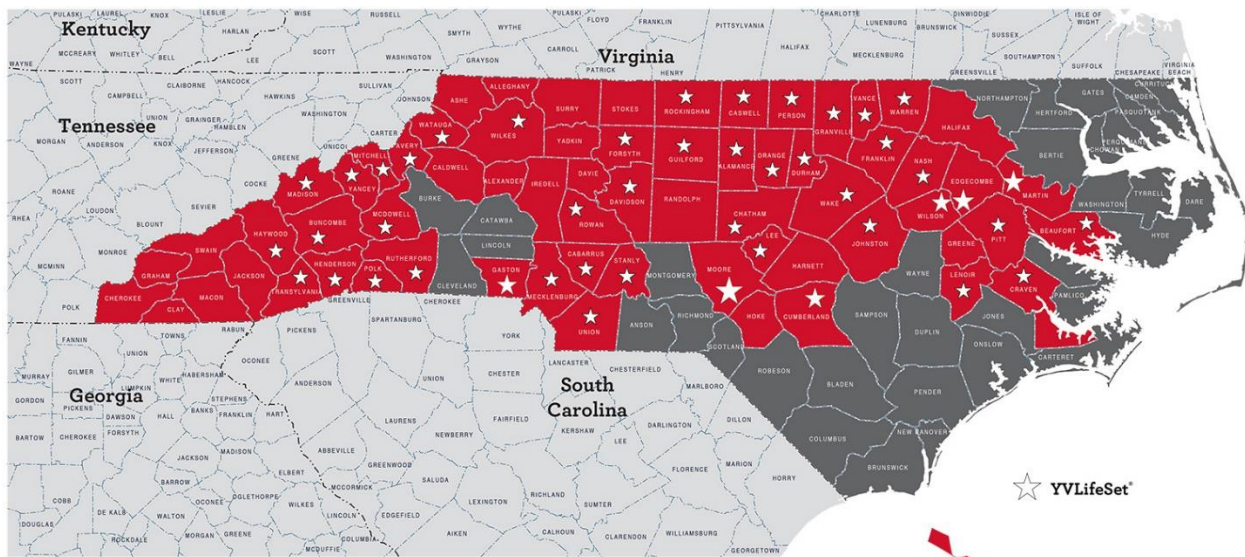
Annie Smith
State Director of Community Based Programs - North Carolina
Annie.Smith@YouthVillages.org
910-673-8501

North Carolina has been working on improving the **array of crisis services**. For children and youth this work includes:

- Three new child facility based crisis centers are under construction with the first to open December 2017. A request for application has been released to support the start of two additional facilities.
- Use of behavioral health urgent care centers.
- Visit to New Jersey to learn about mobile stabilization services in New Jersey, Connecticut, and Massachusetts. DMHDDSAS supported one LME-MCO in developing their mobile stabilization pilot which will launch in February 2018.

Map of **Child Facility Based Crisis Services** that are in the construction/renovation progress:

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Evidenced Based Trauma Services: The General Assembly supports the spread of evidence-based trauma interventions through the Child Treatment Program run by the Center for Child and Family Health. The Child Treatment Program uses a learning collaborative model and rosters clinicians who demonstrate proficiency. The Child Treatment Program has rostered clinicians in the following models:

- Attachment and Biobehavioral Catch-up (ABC) 10 clinicians
- Child-Parent Psychotherapy (CPP)   46 clinicians
- Parent-Child Interaction Therapy (PCIT)   80 clinicians
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)   86 clinicians
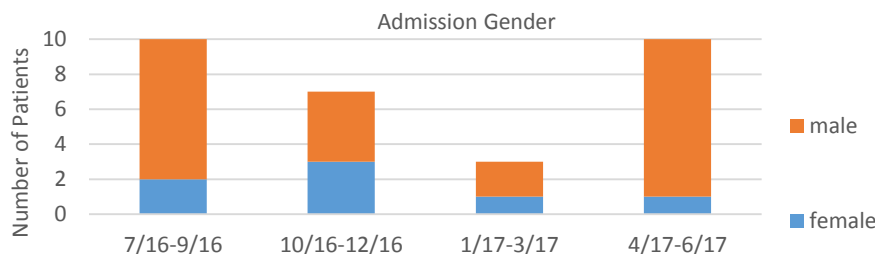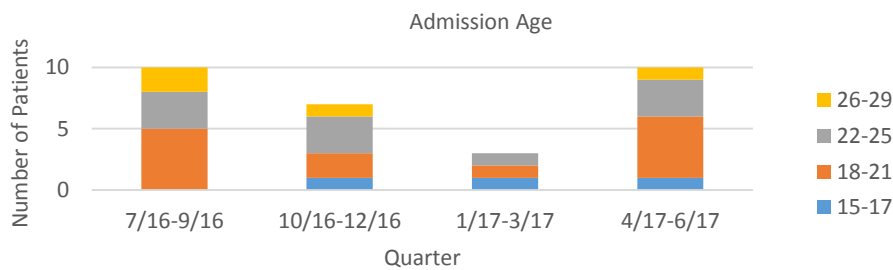- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) 587 clinicians

Services for Youth Experiencing First Episode Psychosis (FEP): North Carolina currently funds three FEP sites and a technical assistance center with mental health block grant funds. The three sites provide early intervention services through evidence based Coordinated Specialty Care teams. DMHDDSAS requires its Coordinated Specialty Care teams to include peer support. One additional site tests innovative practices including ways to increase social support and help young people regain skills and confidence in the social arena. The CSC Teams address the young person's dreams of recovery in addition to addressing symptom reduction.

The technical assistance center has developed a Coordinated Specialty Care Fidelity Monitoring Tool and a quality assurance database to track clinical and programmatic outcomes for all funded CSC sites. The technical assistance center offers monthly training and consultation calls for the disciplines within the CSC Teams including for medication management, individual therapists, family therapists, and supported education and employment specialists.

In addition, the technical assistance center has developed on-line trainings to assist general behavioral health clinicians to identify individuals experiencing FEP and make referrals to the CSC program in their catchment area.

In SFY 17, 110 youth were served by the CSC Teams. This number will increase in the current fiscal year as a new CSC team was added in Charlotte. This new team started accepting clients in June 2017.
Below are some examples of data and outcomes captured in the quality assurance database:

Self-Reported Symptom

Self-Reported Ancestry

Average Weekly Hours for Patients Who are Working and Attending School

Time in Program

27
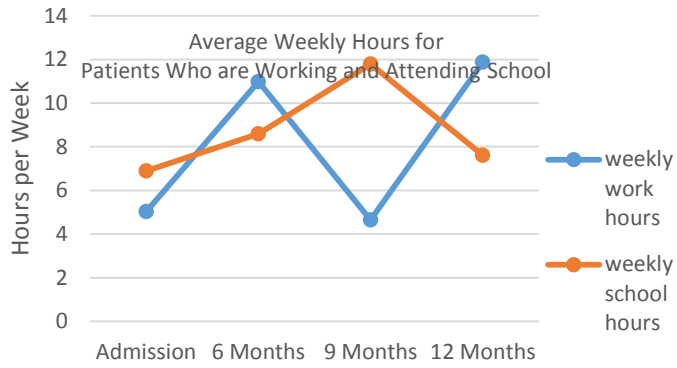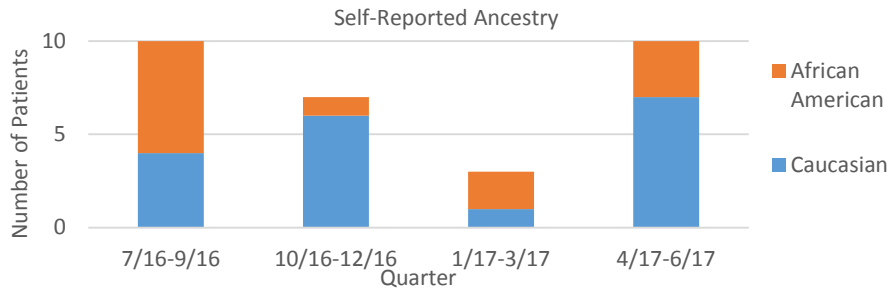
Opportunities to Enhance the Child Service Array: DMHDDSAS will continue its efforts to:
- expand care coordination models including High Fidelity Wraparound and tiers of care coordination
- sustain and expand services and supports for young people with their first episode of psychosis
- expand access to trauma informed intervention through the Child Treatment Program's use of learning collaboratives and rostering of clinicians trained in evidence base trauma models
- expand child crisis services including child facility based crisis centers and mobile stabilization

Domain 2: Integration of Primary Care and Behavioral Health. North Carolina is transforming its Medicaid system by integrating the services and managed care of behavioral health and physical health services in the next three years. In the transition, most LME-MCOs are experimenting with whole person care coordination and several are working on models of co-located behavioral health and primary care services.

Opportunities: The next few years will show an explosion of work in this area across the state.

Domain 3: Workforce Development. The child behavioral health workforce development strategies have focused on:
1) Development of a NC training, coaching, and monitoring institute for High Fidelity Wraparound. This institute will be housed in a university and will sustain and grow the High Fidelity Wraparound pilots developed from the current SOC Expansion Grant. The HFW Institute will provide training, coaching, and certification to new HFW coaches
   - Approve, support, and monitor all HFW teams in NC
   - Provide technical assistance to providers and LME-MCOs on selection of providers and selection of HFW staff
   - Audit fidelity to the NC Wraparound Model. Findings can lead to program improvement plans and additional support.
   - Monitor certification of all HFW roles
   - Include at least one staff member with lived experience
   - Support implementation and quality assurance
2) Support of the Coordinated Specialty Care for young people experiencing first episode psychosis through the NC technical assistance center.
3) Spread of evidenced based trauma interventions through the Child Treatment Program across the state. The Child Treatment Program trains through a learning collaborative model, tests proficiency, and rosters clinicians who have met proficiency standards.

Opportunities: These will be the child workforce areas of focus for the next three years.

Domain 4: Recovery and Consumer Driven Treatment.
All child enhanced service providers are required to take System of Care Child and Family Team training which emphasizes family driven, youth guided care. The Child and Family Team training has been revised in the last 18 months by a committee of the state collaborative and is co-trained by agency and family co-trainers.

Family driven and youth guided care is also a cornerstone of the HFW pilots and the Governor's Task Force Tiered Case Management Pilots.

Domain 5: Peer Support.

In DMHDDSAS' pilot of High Fidelity Wraparound in the SOC Expansion grant, family and youth peer support were embedded within the HFW team at the provider agency. Families can opt for family or youth peer services and most families opt in because the family and youth peer support staff are integrated into the HFW team. DMHDDSAS has written a draft state-funded service definition that includes family and youth peer support. DMH/DD/SAS has also drafted a state service definition for stand-alone family peer support and has committed to explore a pathway for a stand-alone youth peer support service definition.

The SOC Expansion Grant has also embedded Family Partner Coordinators at LME-MCOs. These Family Partner Coordinators support the work of the Community Collaboratives in partnership with the local SOC Coordinator. They bring family voice to other governance activities in their regions and are a resource to their High Fidelity Wraparound Teams.

In addition, DMHDDSAS contracts with NC Families United and NC Youth MOVE for trainings on family driven care and support to local family organizations. Staff from NC Families United are heavily involved in all aspects of implementation support for the High Fidelity Wraparound pilots and SOC Grant Governance. NC Families United assists DMHDDSAS in bringing family and youth voice to request for application review committees and other projects to improve children's behavioral health services in North Carolina.

Opportunities: DMHDDSAS will work with the LME-MCOs to develop in lieu of service definition for High fidelity Wraparound and Family Peer Support. MHHDDSAS will continue to support the work of NC Families United and Youth MOVE.

Domain 6: Health Disparities and Cultural Competency

Domain 7: Quality Assurance and Continuous Quality Improvement.   Through its contracts with LME-MCOs, DMHDDSAS requires quality assurance measures and a continuous quality improvement process. LME-MCOs submit performance data quarterly. Some of the indicators submitted to DMHDDSAS are penetration rates, initiation rates (two initial services with 14 days), engagement rates (initiation visits plus 2 additional services within 30 days), and length of stays in community psychiatric hospitals. This information is reported by age category (3-17 years and 18 +) as well as by funding source.

In addition, NC has an outcome tracking system, NC-TOPPS. Outcome data is gathered at admission, three months, six months, and discharge.   Enhanced providers are required in their LME-MCO contracts to collect NC-TOPPS data. Some examples of the information and outcomes collected in the NC-TOPPS system includes gender, age, race/ethnicity, diagnoses, substance use, attendance at treatment sessions, reasons for ending episode of care, severity of symptoms, quality of life ratings, participation in positive activities, juvenile justice involvement, suicidal ideation and attempts, grades, school suspensions and attendance, housing, crisis service use, whether service needs were met, barriers to treatment, and helpfulness of treatment.   DMHDDSAS, LME-MCOs, and providers can run aggregate and individual client level reports in the NC-TOPPS system. In addition, there is a public interface so that consumers and Community Collaboratives can run reports for child services in their region.

Below are a few examples of child and adolescent outcomes from NCTOPPS.

Child Outcomes

Consumer Ratings on Quality of Life % Rated 'Excellent' or 'Good' N = 2,169	Year Before Treatment (Initial)	Past 3 Months (EC)
Emotional Well-Being	23.1%	59.4%
Physical Health	83.9%	90.0%
Family Relationships	38.6%	65.1%
Living/Housing Situation	71.4% N = 2,155 *	80.1%
* - Interview(s) were completed after the question was added to NC-TOPPS.		

Experienced Abuse N = 2,169	3 Months Before Treatment (Initial)	Past 3 Months (EC)
Physical Violence Experienced	35.5%	27.3%
Hit/Physically Hurt Another Person	73.3%	49.6%

Sample Adolescent Outcomes

Consumer Ratings on Quality of Life % Rated 'Excellent' or 'Good' N = 4,586	Year Before Treatment (Initial)	Past 3 Months (EC)
Emotional Well-Being	36.1%	63.3%
Physical Health	79.9%	86.4%
Family Relationships	40.4%	61.3%
Living/Housing Situation	69.7% N = 4,555 *	77.2%
* - Interview(s) were completed after the question was added to NC-TOPPS.		

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Experienced Abuse N = 4,586	3 Months Before Treatment (Initial)	Past 3 Months (EC)
Physical Violence Experienced	31.5%	20.1%
Hit/Physically Hurt Another Person	48.7%	29.2%

Suicide Ideation and Hurting Self N = 4,586	Ever (Initial)	Since Last Interview (EC)
Suicidal Attempts	20.8%	2.7%
	3 Months Before Treatment (Initial)	Since Last Interview (EC)
Suicidal Thoughts	26.5%	10.3%
Tried to Hurt or Cause Self Pain	20.2%	7.6%

Opportunities: The Cross System Work Group has identified an action team to explore improved ways to share data across systems to improve services and collaboration.

North Carolina Families United (NCFU) Info Sheet

This Non-profit was formed in 1997. Like most family – run organizations, North Carolina Families United was created around a kitchen table by dedicated parents eager and frustrated to create policy change in schools, medical practices and their communities that would not only help their children but those that were to come that struggle from emotional and behavioral issues. As the one and only **STATEWIDE Family-run organization**, and **state chapter of the National Federation of Families**, NC Families United has a board of directors' composition of 51% consumer family member board.

North Carolina Families United, Inc. (NCFU) managed to grow with small grants from various sources that enabled it to hire fellow family member, Gail M Cormier, who is credited with building up a provider and youth organization in New Hampshire as its first Executive Director. Cormier was also the co-creator and first director of the Youth Mentor Care Coordination program RENEW. Since 2006 when Cormier was hired at NC Families United; the struggling group has grown from 35,000 a year annual budget to over $800,000.

In the *State Plan 2003: Blueprint for Change – July 1, 2003* identified "family to family support" as the first of the domains in the "array of supports and services that are part of the integrated comprehensive provider network system for children and their families" (p. 119). The importance of participants and families in the delivery of services was reiterated in *The State Strategic Plan 2007-2010* and continues today. NC Families United mission supports and unites the voices of children, youth, and families with mental health concerns to educate, support and advocate for improved services and lives

There have been many things North Carolina Families United has been able to accomplish with the block grant funding over the years to create a foundation of support for families and youth. These accomplishments have created a change in culture for family and youth driven voice and services. Because of the block grant funding

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North Carolina has been able to advance the workforce development of Family Partner Peer Support and Youth Peer Support throughout the state.

Family Partner Workforce Development in 2008 NC Families United with funds from the block grant held its first quarterly meeting in Lenoir, NC. Six Family Partners were present, today between 40-75 family partners attend the meetings. Family Partners from all corners of the state are plugged into the meetings from Roanoke Rapids, to Morganton, NC. Over the past 8 years family partners have crafted a well thought out Family Partner definition, competencies, and trainings that are needed to support a Family Partner to be able to accomplish job tasks at the greatest competencies for the position. (see www.ncfamiliesunited.org) NC Families United staff and the Family Partners from around the state designed and implemented the Family Partner 101 training. To date, almost 500 Family Partners have been trained in Family Partner 101. NC Families United was invited to the National Federation of Families in Maryland to discuss the need for a national certification; NC Families United provided technical assistance and help design the national Parent Support Provider definition and certification using the NC Families United framework. Next, in our state NC Families United collaborated with ParentVoice in Charlotte, NC to establish a training institute to train potential Family Partners. Training involves the 5 mandated trainings and 2 electives to be able to successfully become a national certified Parent Support Provider and to be able to support families in NC by using the best practice tools and supports provided by the trainings. To date, NC has the most nationally certified Family Partners (47) in the country as the country moves to national trainings and procedures to provide fidelity in the workforce. NC Families United led the way to help provide scholarships for Family Partners to be able to take the very expensive test and vetting procedures. By establishing a reoccurring line item in the collaborative funds NC Families United established for the state collaborative, Family Partners are able to take the initial test for free. Every three years certified Parent Support Providers must pay for certification renewal on their own at $250.00. Currently the number of active Family Partners in our state stands at 420 members who have taken Family Partner 101 and are on our invited and update elist. This includes Family Partners who are employed full time and nationally certified to Family Partners working in a grass roots volunteer process with their friends and neighbors and are not nationally certified but trained at least in Family Partner 101.

The reach of NC Families United trained Family Partners working at least 20 hours or more can be found at family organizations like NC Families United, Parent Voice and Families Supporting Families of Halifax. Alamance DSS and Bladen County DSS both support 1 full time Family Partner each. NC Families United holds the contract for the full time Family Partner embedded at the Alamance DSS. NC Families United provides TA to the Bladen County DSS staff and support to the Bladen County DSS Family Partner under the block grant deliverables. MCOs like Partners, Smoky and Alliance all independently employ Family Partners. Today there are 3 full time Family Partners in Partners, 4 in Smoky and 2 at the Alliance. ECBH had 3 Family Partners until the merger. During the merger Trillium disbanded those positions. CenterPoint and Eastpointe contract through NC Families United for Family Partners on a part time basis. CenterPoint contracts for up to 3, and Eastpointe contracts for 20 hours of one Family Partner.

In addition, the System of Care Expansion grant has part time Family Partners in 5 MCOs and 5 Family Partners doing peer support at 5 providers. Family Partners are also found employed at schools, private providers and at Universities like UNCG, NC State and UNC Charlotte. NC Families United provides TA to all Family Partners when needed through the block grant funds.

Providing Culture change through Family Driven Training, NC Families United, as the state chapter of the National Federation of Families was able to use their Family Driven curriculum training to train cross systems participants to understand the history of why family driven? Why Family and youth voice? Funding for the

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training is provided by the block grant. This training has proven to be highly effective culture shift training. It allows participants to freely and safely discuss barriers to full family involvement and agency acceptance. Shifts in understanding what family driven means has happened all over the state. A good example of this culture shift has been in Goldsboro. Less than 2 years ago agencies did not understand the value of family voice and participation. In fact when staff were learning about system of care, one county agency person asked if they were going to have to implement this new system of care thing now. Today, Goldsboro has the SOC Expansion grant, 1 full time Family Partner at the MCO and a very strong Wraparound team with a Family and Youth Partner each.

Leveraging funding and leading the way!

The foundation of support the small funding provided by the Mental Health Block grant has stabilized our organization to create a reliable and consistent presence in statewide development. NC Families United led the development of the SOC Statewide Planning grant that subsequently brought in a 5 year SOC grant to our state, bringing in over 6 million dollars for services to support children, youth and families. NC Families United also worked with the Durham and Alamance group to develop their SOC grants. Those two grants brought to the state of NC 12 million dollars. Those two counties recognize that it was with NC Families United insight and understanding of family needs, those grants would not have contained the services needed to help NC Citizens and therefore would not have been funded. Recently Partners Behavioral Health also enlisted NC Families United and received another 4 year SOC grant, again bringing in funding to the state.

System of Care, Family and Youth Trainings because of the block grant funding, NC Families United has been a leader at the table designing, updating and developing CFT 1, CFT 2, Family Partner 101, Youth Peer 2 Peer, Youth Leadership Series, How to Pick a Provider, the SOC Tool Box. These trainings and tools have long provided SOC Coordinators, providers, families and youth tools, support and knowledge. Some are currently due for updating. NC Families United is planning to follow the CQI process to use implementation science to update the trainings and create a transfer of learning process to most of these trainings. Because of our lead in trainings, NC Families United was asked by the State Collaborative to be the keeper of the SOC online trainings. Those trainings include SOC 101, CFT 1 and cultural competence training; two training videos are also included. These training bring into the organization about an average of $4,000 a month. NC Families United board and Executive Director have designated those funds to be used to support the state collaborative goals and needs. These funds have supported Heart 2 Heart training by NC State, SAYSO trainings, a statewide research project measuring SOC, Early Childhood workforce development trainings and more. Currently the state collaborative led by support from NC Families United is planning it's first State Conference in several years to take place in May.

Family and Youth Voice Parents and professionals working collaboratively as partners are now recognized as a best practice and now enjoy a partnership in planning for System of Care sustainability and expansion supported by the SOC Expansion Planning and Implementation grants. These collaborative partnerships have resulted in measurable and direct positive benefits for families, children and providers. The work is based upon and built through careful and targeted attention to the development of partners and collaborators at every juncture of the work. NC Families United continues to work with current long-term partners to collaboratively effect change and ensure the development of a quality "system of care" for children and their families. It is the goal to leverage resources by partnering with other programs, agencies, and services; sharing resources and tools, cross dissemination of information, and complimenting the efforts of all partners. NC Families United continues to work closely with: *State Collaborative for Children and Families* provides a forum for collaboration, advocacy and action among families, public and private child and family serving agencies and community partners to improve

outcomes for all children, youth and families. Both the Family Co-Chair and the Family Co-Vice Chair are NC Families United Family Partner Coordinators. NC Families United has its board members, staff or affiliate parents involved in all areas of concerns that need authentic family and youth voice. Including the State SOC Expansion Planning and Implementation Steering Committee, the *State Mental Health Planning Council* that serves as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems and monitors, reviews, and evaluates the allocation and adequacy of mental health services within the state. Mental Health Association in NC promotes mental wellness through advocacy, prevention and education through regional and local chapters across the state. *NC Council of Community Programs* improves service quality and management effectiveness by providing its member programs with a strong, cohesive, statewide voice through policy analysis, technical assistance, publications, and educational programs. *NC Mental Health Consumer's Organization* is a peer run nonprofit that offers advocacy and support to adults with mental illness. *Developmental Disabilities and Substance Abuse Services (MHDDSAS)* implements the public mental health, developmental disability and substance abuse service system; including the orchestration of the NC System of Care. *NC Division of Social Services* provides training, technical assistance, and consultation to the local staff who work in programs for families and children including Child Welfare, Family Support, Work First, Child Support, and Food and Nutrition Services. *NC YouthMOVENC, a program of NC Families United* provides team building activities and leadership skills training for youth with mental health concerns. The NC Disabilities Rights Council and Nationally the Federation of Families and FREDLA, Family –Run Executive Directors Leadership Association.

On the state collaborative sub committees are staff –Renee Cordero is the administrative support to the North Carolina Collaborative for Children, Youth, and Families an organization consisting of representatives from the Division, the Department of Public Instruction, the Office of Juvenile Justice and Delinquency Prevention, the Department of Health and other public child-serving agencies, Local Management Entities, multiple provider organizations and community agencies that has had some influence on policies formulated and decision made on children's health and well-being. Family members associated with NC Families United, Teka Dempson is a member of the Board of Directors for the National Federation of Families for Children's Mental Health. Teka is the Lead Family Partner/Family Partner Coordinator for the BECOMING Project, the current funded SOC site in Durham County. In addition other NCFU board members and family partners such as Board Chair - Mary Lloyd and Board Chair Emeritus - John Deir sit on various state mental health driven policy committees to help promote and support family and youth involvement and voice. Because of the recurring funding from the Mental Health Block grant, NC Families United has been able to grow family partner support and family, youth and consumer voices in all regions of the state. Garron Rogers, the Youth Transition Director helped lead the way on the Raise the Age Campaign. Gail Cormier, Executive Director is a member of the SOC Expansion Leadership team, steering committee and the cross-systems advisory team. NCFU former staff and board members continue to sit on various long standing committees they obtained during employment and board terms by NC Families United . NCFU also has 132 youth who have graduated from NC Families United Youth Leadership Series attending the state collaborative meeting, mental health planning council, NC State Family Involvement Policy meeting and the NC Transition Collaborative committee, FACTT committees and local collaborative. Reclaiming Futures in Mecklenburg, Forsyth and Wayne Counties. NC Families United also has many family members who attend local collaboratives, care reviews, Reclaiming Futures committees, the state collaborative sub-committees (training, Transition, SOC Conference Planning, School Based MH, etc) and more. The growth of consumer involvement can only be sustained and enhanced by the block grant dollars. It is best practice to support family and youth consumer leaders to bolster positive outcomes in the areas of primary prevention universally and selectively. These indicated prevention activities will help families and youth not yet

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identified as needing treatment to seek and find services enhancing positive mental health and behavioral health outcomes for citizens of our state.

The block grant has always support youth leadership development. Our NC Families United Youth voice has grown because of funding. NC Families United's Powerful Youth United has developed in YouthMove NC. Through the RENEW model of peer mentorship and youth leadership, youth and emerging young adults have been trained and supported to lend their voice to support their needs and the needs of the youth in their communities. RENEW youth funded by this grant have successfully graduated from high school, gotten jobs and went on to college. Youth MOVE NC local chapters are developing throughout the state from Wilmington to Surry County. RENEW is a structured school-to-career transition planning and individualized wraparound process for youth with emotional and behavioral challenges. The (Rehabilitation for Empowerment, Natural Supports, Education and Work) model focuses on supporting young adults to design and pursue a plan for the transition from multiple access points to adult life. In North Carolina, RENEW 62 transition aged youth from diverse regions of the state struggling with severe emotional behavioral health and/or co-occurring disorders have been recipients of intensive coaching and mentoring. The delivery of RENEW services has substantially increased the high school completion, employment, and post-secondary education participation rates among our most vulnerable youth and reduction in behavior problems in school, home and in the community. Additionally, young adults report improved management of symptoms, reduced juvenile justice involvement and increase self-determination and self-efficacy. Strategies such as futures mapping, flexible fund/ resource development and flexible educational options were used with:

Demonstrating Co Partnership a true value of System of Care and real Family and youth voice is to hold true to co training and co facilitating with an agency and family partner. At the collaborative NC Families United ensures that the collaborative and sub committees all have co-chairs. In addition the State SOC Coordinator, Terri Grant and the Executive Director Gail Cormier attend regional SOC Coordinator meetings together each quarter, Family Partner Quarterly meetings and try to reach as many local collaboratives together as possible to support each other and to demonstrate true partnership.

Outreach to Families Across the state and events, although the block grant does not fund all of these activities, NC Families United hosts family cafes in 3 areas during each month, YouthMove meetings are held once a month and other local area trainings and events are held each month.

NC Families United receives on average 42 calls per week about supports for children, families and youth as well as calls requesting information on trainings and health insurance. Recently, a majority of calls have been focusing on adolescents and school supports for behaviors.

Children's Mental Health Awareness Month, since 2009 NC Families United has collaborated with other state and local family organizations to promote and disseminate information on children's mental health. NC Families United has designed Governor Proclamations for the event, legislative meetings, rallys and most recently an annual dinner. This year's highlights will happen on the eve of the first day of the state conference and will also feature a turn the Governor's mansion Green on May 5th. Because of these efforts individual county efforts now run independently and happen each may to celebrate the reduction of stigma and information for Children's Mental Health.

Cross System Collaboration is the most important push for real system of care and family and youth voice, because of the funding of the block grant, NC Families is seen as the "go to" family organization for DPI, DSS and

DJJ. Recently DSS had a series of full day work groups for planning for the development of the CFSR-PIP. Five themed workgroups that cut across the 7 Outcomes and 7 Systemic Factors found within the results report to DSS. Kevin Kelly approached the Executive Director to help find multiple families to attend the 5 work group sessions. NC Families United paired experienced Family Partner Coordinators with multiple family members to attend each session. DSS found funding to pay for family members for their day, plus mileage. The results were a strong and positive experience for families and agency attendees. Below are some of the family comments, followed by agency comments.

Family Members said when I asked "3 questions if you don't mind sharing: Did you feel like you were heard today? Did you feel safe sharing your story? Were you treated as an equal?"

"yes it was a great experience. mine was number six. third on the top five to be implemented."

"I didn't know what to expect but it turned out to be a really good experience"

"What a blessing (stipend) and great experience"

"Yes yes and yes everyone was so nice"

"yes i felt like i was heard also felt comfortable and safe with sharing my story...Yes i felt treated equally as well.Thanx for the invite"

Agency Members said
"I didn't realize how impactful having parents involved with child protection in the room."
"DSS needs to find money to pay for embedded Family Partners"
"A true powerful experience."

<u>Youth MOVE North Carolina</u>

GOALS, HIGHLIGHTS, & BARRIERS

Goals

1. Expanding Youth MOVE across the state by developing local chapters.

2. Writing and recording public service announcements to bring more awareness to mental health and wellness to combat stigma.

3. Recruiting and training more youth advocates.

4. Training adults on how to more effectively engage and partner with youth.

Highlights

*   Members of Youth MOVE North Carolina co-presented the workshop "Got Youth Voice?" with the Youth Transition Director and Youth Coordinator at the National Federation of Families for Children's Mental Health Conference in November 2017.

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- Members of Youth MOVE North Carolina met with state secretary of DHHS Mandy Cohen's staff to discuss service needs for youth and young adults as well as the importance of youth peer education and support services.
- Youth MOVE North Carolina members serve as part of the System of Care Governance Committee; one member participated in the committee's two-day strategic planning session in late August 2017.
- Members of Youth MOVE North Carolina conducted a day long training on youth voice and how organizations could work towards developing their own Youth MOVE Chapters in August 2017 (Over 12 counties had youth and supportive adult representation in attendance!)
- Two new local chapters have been officially awarded by Youth MOVE National since the summer of 2017: Stokes County Youth MOVE (June 2017) and Powerful Youth Leaders of Guilford County (November 2017). We anticipate at least two other regions formally applying for local chapters within the next six months to one year (Rowan/Cabarrus Counties and Caswell/Orange/Person/Alamance).
- Youth MOVE North Carolina members have presented on the impact of youth voice in the decision and policy making process at various local community collaboratives and managed care organizations throughout the state of North Carolina in 2017. Members also attend the North Carolina State Collaborative on Children, Youth, and Families.
- Members of Youth MOVE North Carolina have given feedback on the service definition of youth peer support to the state.
- One member of Youth MOVE North Carolina attended the Child and Adolescent Research and Policy Conference in Tampa, FL in March 2017.
- Two members of Youth MOVE North Carolina received full scholarships to attend the Association of Programs for Rural Independent Living Conference in Spokane, Washington in October 2017.
- We have provided technical assistance and/or youth engagement advice across the state of North Carolina to agencies or persons in the following counties: Hoke, Orange, Caswell, Person, Chatham, Alamance, Durham, Forsyth, New Hanover, Sampson, Bladen, Wake, Vance, Cabarrus, Rowan, Buncombe, Guilford, Forsyth, Wayne, Stokes, and Mecklenburg.
- Youth Transition Director has been an active member of the NC Raise the Age Coalition presenting in Sampson, Alamance, Wake, Bladen, and Durham Counties and met privately with NC Deputy Commissioner of Juvenile Justice. Through our efforts we helped get legislation passed to help North Carolina become the final state to raise the juvenile age of jurisdiction so 16 and 17-year olds would no longer be criminally charged as adults with the exception of high level felonies. Youth Transition Director also received a personal invite from Governor Cooper's office to attend an event recognizing Raise the Age advocates in July 2017 at the state capital.
- Youth Coordinator planned a successful Youth Leadership Series from March to May 2017 that included workshops on team building (ropes course), Wellness Recovery Action Planning, LGBTQ Equality, How to Share Your Story, Cultural Competency, and a graduation ceremony that included laser tag.

Barriers

- Staffing/Resources
- Transportation

Crisis Services

Crisis Solutions Coalition Workgroup

The Crisis Solutions Initiative Coalition workgroup includes members from various statewide organizations partnering to improve NC's behavioral health system's crisis response capacity. The Coalition works to develop and design strategic solutions for improved care for individuals who may experience a MH/IDD/SU crisis in order to reduce the number of visits to Emergency Departments and an increase in utilization of alternate community based services/facilities.

- At the last Crisis Solutions Coalition meeting, several stakeholders presented on the Local Community Partnerships Network developed in Asheville, NC, including panel presenters from RHA, Vaya Health staff, and Mission Hospital, the Cures Grant and Opioid Treatment Programs, Innovations Waiver Crisis Services, and the upcoming Behavioral Health Crisis Referral System.

Facility Based Crisis Centers (FBCCs) and Behavioral Health Urgent Care Centers (BHUCs)

BHUCs are outpatient facilities that provide walk-in crisis assessment, referral, and treatment for adults with an urgent or emergent need for mental health, intellectual or developmental disabilities, or substance abuse services. Licensed behavioral health professionals and medical staff with prescriptive authority provide services. NC currently has six 24-hour BHUC facilities with plans for one more site that will be supporting communities

FBC Centers are licensed 24-hour residential facilities that provide short term acute crisis stabilization (comprehensive clinical assessment, treatment intervention, behavior management or support plan) for children and adolescents, or adults who have a mental illness, intellectual or developmental disability, or a substance use disorder. NC currently has 23 facility based crisis centers with 313 licensed beds; twelve are IVC designated.

Community Behavioral Health Paramedicine Pilot Program

The Community Paramedicine BH Crisis Transport pilot program is an emergency department diversion program for individuals in behavioral health crisis to community alternatives for specialty behavioral health crisis intervention. Currently, nine sites operate within five LME-MCO catchment areas. Persons are treated at the scene or diverted to an FBC or BHUC.

Psychiatric Advanced Directives (PADs)

PADs allow competent persons, through advance instructions and/or appointment of a surrogate decision maker, to state their preferences for future behavioral health treatment in the event of an incapacitating psychiatric crisis. We are currently training healthcare professionals and staff in how to develop and use PADs.

<u>Access to Care</u>

Access to Care is monitored through contractual requirements and performance metrics that are reported quarterly.

Standards

- Emergent Care - Assessment and/or treatment within 2.25 hours of the request for care.
- Urgent Care - Assessment and/or treatment within 2 calendar days of the request for care.
- Routine Care - Assessment and/or treatment within 14 calendar days of the request for care.

Additional Monitoring

- Annual Perception of Care Survey
- NC-TOPPS

Annual Gaps and Needs Assessment

- The LME/MCO Community Mental Health, Substance Use and Developmental Disabilities Services Annual Needs and Gaps Analysis is one part of a continuous assessment and action process with each component driving the focus of the next:

  o LME/MCOs **Assess** and study the LME/MCO's community to determine needs and providers to deliver services;

  o LME/MCOs develop or update LME/MCO strategic **plan**s, such as local business plans, network development plans and strategic initiatives, as needed, to incorporate results from the LME/MCO service needs assessment and gaps analysis;

  o LME/MCOs implement strategic plans through local initiatives, quality improvement projects and other **act**ions;

  o LME/MCOs review and **assess** action steps taken and determine progress and challenges in meeting needs and adjusting resources to respond to gaps in services.
  Annually the LME/MCOs submit a Gaps and Needs analysis that is reviewed and approved by DMH/DD/SAS.

- In the event that the LME/MCO has a gap in a service area they submit a service exception request and answer the following questions:
  o Number of providers of the service under contract
  o Number of individuals receiving the service
  o Number of individuals in need of the service
  o Reasons why the access and choice standard cannot be met
  o New request or have you previously requested exception
  o Plan for how the LME/MCO will meet an individual's need for access or choice to the service
  o Expected ending date of this exception
  o Follow-up is done on a quarterly basis through the Interdepartmental Monitoring Team.

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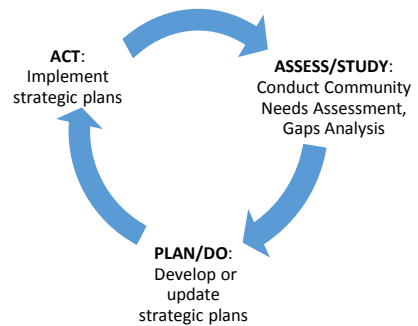
Urban & Rural Areas of North Carolina

North Carolina
US OMB Metropolitan (Urban) and Non-Metropolitan (Rural) Counties

Metropolitan (Urban) and Non-Metropolitan (Rural) Counties
- Metropolitan (Central County)   (30 counties)
- Metropolitan (Outlying County) (16 counties)
- Non-Metropolitan (Rural)   (54 counties)
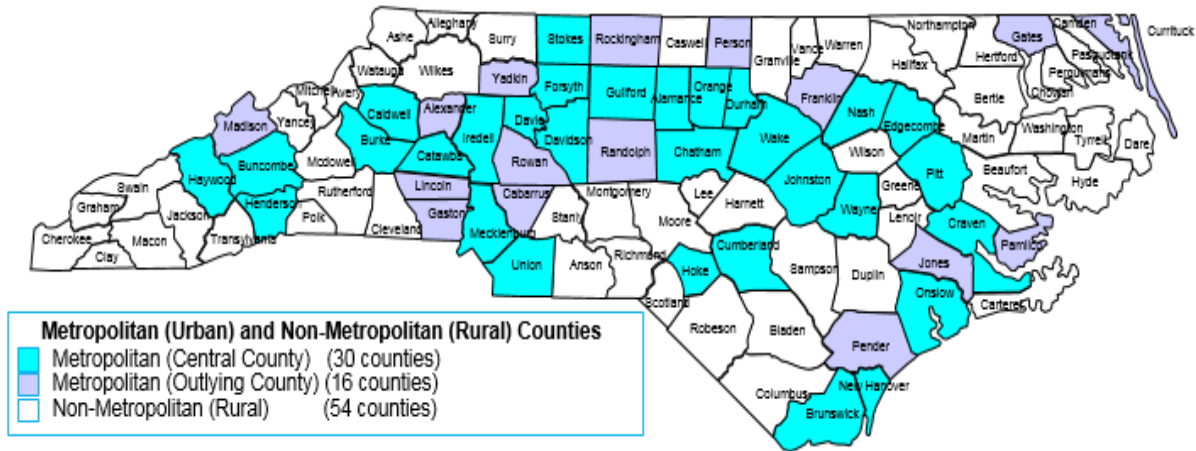
Urban includes Metropolitan counties (46 counties).
Rural is anything other than Metropolitan counties (54 counties).
Central County - at least 50 percent of the population resides within urban areas of 10,000 or more population or contain at least 5,000 people residing within a single urban area of 10,000 or more population.
Outlying County - included in the Metro/Micro Statistical Area if they meet specified requirements of commuting to or from the central counties.
Data Sources: http://www.census.gov/population/metro/data/def.html (July 2015)

Source: U.S. Census Bureau, Population Division; Office of Management and Budget, July 2015 delineations, http://www.census.gov/population/metro/data/def.html, Internet Release Date: April 2016, Downloaded 7/15/16. The United States Office of Management and Budget (OMB) delineates metropolitan and micropolitan statistical areas and designates counties as Metropolitan, Micropolitan, or Neither according to published standards that are applied to Census Bureau data. The general concept of a metropolitan or micropolitan statistical area is that of a core area containing a substantial population nucleus, together with adjacent communities having a high degree of economic and social integration with that core. A Metropolitan area contains a core urban area of 50,000 or more population. OMB considers all counties that are part of a Metropolitan Statistical Area (MSA) to be urban and all counties that are not part of an MSA to be rural. In NC there are 46 metropolitan (urban) counties and 54 non-metropolitan (rural) counties. The above table shows the counties that are designated as metropolitan (urban) counties. All undesignated counties are non-metropolitan (rural). The micropolitan counties that are part of the non-metropolitan (rural) group of counties are not annotated. Under the standards, the county (or counties) in which at least 50 percent of the population resides within urban areas of 10,000 or more population, or that contain at least 5,000 people residing within a single urban area of 10,000 or more population, is identified as a "central county" (counties). Additional "outlying counties" are included in the MSA if they meet specified requirements of commuting to or from the central counties.
Source: http://www.census.gov/population/metro/about/

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How LME-MCOs and State Psychiatric Hospitals (SPHs) Coordinate Behavioral Health Services

- SPHs routinely update LME/MCOs concerning hospitalized beneficiaries from their respective catchment areas, sending daily admission and discharge reports to the LME/MCOs, accordingly.
- SPHs are committed to returning people to their communities when well, and begin discharge planning as early as possible after admissions.
- LME/MCOs, via their hospital liaisons, work with the SPHs to assist with discharges.

Use of Telehealth to Deliver Behavioral Health Care

Delivering State Funded Behavioral Health Services Using Telehealth

NC DMHDDSAS has funded the use of telehealth (also referred to as telemedicine or telepsychiatry) in the delivery of selected behavioral health services since 2007. The policy that NC DMHDDSAS has employed to guide the funding of services delivered via telehealth for persons, who rely on state-funding and who do not have Medicaid or other third-party health insurance, is the NC Division of Medical Assistance's *Telemedicine and Telepsychiatry* Clinical Coverage Policy No. 1H. This Medicaid policy was first implemented in 1999. https://files.nc.gov/ncdma/documents/files/1H.pdf

History of NC DMHDDSAS' Involvement with Telehealth

NC DMHDDSAS received funding from the NC Rural Health Foundation to award grants to ten (10) pilot programs managed by ten Local Management Entities (LMEs) and selected providers in 2007 and 2008. In State Fiscal Year (SFY) 2008-09, NC DMHDDSAS allocated $1,650,000 to LMEs for the purchase of telepsychiatry equipment to be used in Walk-In Crisis and Immediate Psychiatric Aftercare centers. NC DMHDDSAS posted Guidelines for the Use of Telepsychiatry in April 2010 to the NC DMHDDSAS website.

Growth of the Use of Telehealth for State-Funded Behavioral Health Services

The following tables, presents data that was retrieved from claims that were paid for services delivered via telehealth in SFY 2011-12 and SFY 2016-17. A substantial increase in the use of the telehealth delivery modality in reflect in Table 1.

Table 1: Claims Data Comparison: SFY 2012 & SFY 2017
State Funded Telepsychiatry

State Fiscal Year	Persons Served	Dollar Value
SFY 2012	2,967 (some duplication possible)	$419,304
SFY 2017	5,380 (unduplicated)	$872,295

Table 2 reflects the dollar value and persons served by age and disability groups in SFY 2016-17. Adult with mental illness represent the age and disability group with the highest dollar value and number served.

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Table 2: Claims Data: SFY 2017 State-Funded Telepsychiatry
By Age & Disability Groups

Age/Disability Group	Dollar Value	Persons Served
Adults/Mental Illness	$720,414	4,398
Adults/Substance Use	$136,119	1,023
Children/Mental Illness	$15,636	113
Children/Substance Use	$126	2
Total	**$872,295**	**5,380**

The top five services that were delivered via telehealth are depicted in Table 3, along with the corresponding dollars values and persons served.

Table 3: Top Five Services Delivered via Telepsychiatry
SFY 2017

Code	Service	Dollar Value	Persons Served
99214	E & M – Moderate-Estab. Pt. – Telemedicine	$324,118	2,096
99213	E & M – Detailed-Estab. Pt. – Telemedicine	$183,837	2,007
99204	E & M – Moderate-New Pt. – Telemedicine	$98,031	761
90792	Interactive Evaluation-Telemedicine	$83,597	828
99205	E & M – High-New Pt. – Telemedicine	$33,946	230

NC Statewide Telepsychiatry Program in Emergency Departments

In August 2013, the NC Department of Health and Human Services (DHHS) submitted a *Statewide Telepsychiatry Program Plan* to the Senate Appropriations Committee on Health and Human Services House Appropriations Subcommittee on Health and Human Services Joint Legislative Oversight Committee on Health and Human Services and Fiscal Research Division.
https://www.ncga.state.nc.us/documentsites/committees/JLOCHHS/Handouts%20and%20Minutes%20by%20Interim/2013-14%20Interim%20JLOC-HHS%20Handouts/October%208,%202013/Reports/SL%202013-360%20Sect%2012A.2B%20Statewide%20Telepsychiatry%20Program%20Plan%208-15-13.docx.pdf

The *Statewide Telepsychiatry Program Plan* was developed to improve access to psychiatric assistance to persons with behavioral health crises who seek help in Emergency Departments (EDs). ED physicians request and receive psychiatric consultation from a remote psychiatrist via the use of telepsychiatry. Improved access is intended to:
- Reduce the length of time that the individual in crisis must wait for behavioral health assessment and referral to an appropriate level of care; and
- Reduce costs by avoiding unnecessary admissions to the most expensive and restrictive services available, psychiatric inpatient care in hospitals.
  In response to the submission of the *Statewide Telepsychiatry Program Plan*, the NC General Assembly appropriated $4 million over a two-year period, followed by additional funding of $1.5 million from the Duke Endowment.

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A 2016 profile the NC Statewide Telepsychiatry Program (NC-STeP) provides an overview of the initiative: https://files.nc.gov/ncdhhs/2016%20NC%20DHHS%20ORH%20Telepsychiatry%20One%20Pager.pdf

Outcomes have been updated since the above 2016 profile was posted. Since the inception of the NC-STeP in November 2013 through June 2017, the following impacts have been documented:

- 26,699 telepsychiatry assessments of ED patients since Nov. 2013
- 25% reduction in median length of stay for ED patients
- Estimated savings of $15 million
  NC-STeP has demonstrated the following outcomes in the quarter, April through June 2017:
- 43 hospitals participating as of 6/30/2017
- 19 additional hospitals in credentialing process
- 1,187 assessments
- Median LOS = 33.7 hours
- 48.8% of 677 ED patients had IVCs removed when discharged
- 41.5% discharged to home
- 37% discharged to another facility

Telehealth Moving Forward in North Carolina

The DHHS Office of Rural Health and Community Care submitted a *Report on Telemedicine Study and Recommendations* to the NC Joint Legislative Oversight Committee on Health and Human Services on October 1, 2017. https://d3n8a8pro7vhmx.cloudfront.net/fiscalhealthnc/pages/1443/attachments/original/1507145896/SL_2017 -133_Section_2_DHHS_Study_and_Recommend_a_Telemedicine__Policy_10-2- 17_%28002%29.pdf?1507145896

The following recommendations were included:
- "aggressive statewide telemedicine policy" to improve health and increase access to high quality care;
- Improve access to healthcare workforce via
- Interstate Licensure Compacts (e.g., PSYPACT)
- Increase incentives for providers to reach underserved areas
- Enact recommendations of NC Office of Broadband Infrastructure's 2017 Broadband Report
- Establish Legislative Subcommittee to develop comprehensive telemedicine implementation plan

NC DMHDDSAS will continue to collaborate with its sister agencies in DHHS, LME-MCOs, providers, and other interested partners to promote the use of telehealth as a vehicle to increase access to behavioral health care for persons in North Carolina.

Cultural Competency

Removing the Elephants in the Room & Broadening Your Cultural Lens, both trainings, explore cultural issues NC's behavioral health system faces, e.g., by examining the Cultural Formation section of the DSM-5 and the ethical principles that govern licensed professionals.

Removing the Elephants in the Room training
- 30+ trainings; began February 2015, continues with most recent training offered December 2017
- LME-MCOs, AHEC, Provider agencies

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- Provider staff at all levels, LME-MCO staff at all levels, State & Local CFAC members, family members, advocates, AHEC staff
- Mental Health & Substance Abuse agencies
- Substance Abuse agency had entire staff trained (~ 180)

Broadening Your Cultural Lens
- 10+ trainings; began May 2017
- Mental Health First Aid instructors, court counselors, juvenile justice professionals, school staff, law enforcement, probation, child welfare

Broadening Your Cultural Lens: Social Determinants and Health Disparities
- This is phase 2 of the previous trainings and will begin January 2018
- Explores ways in which social determinants of health and culture intersect

LME-MCOs and Provider Agencies

LME-MCOs and Provider Agencies often develop their own cultural competency related activities, tools and trainings, influenced by division related trainings. The division does not develop or direct the development of cultural competency trainings, however, its work often influences LME-MCO / Provider outputs in this regard. Examples include:

- Cultural Competency Plan
- Cultural Competency Review Tool
- Cultural Competency Assessment
- Cultural Competence Provider Council
- Online trainings
- Instructor-Led trainings

The fundamental precepts of cultural competence include developing respect for differences; cultivating successful approaches to diversity; increasing awareness of one's self and of unstated institutional cultural norms and practices; and having a working knowledge of the history, culture, beliefs, values and needs of diverse people and communities. A culturally competent approach to services requires the system to examine and potentially transform each component of mental health, intellectual and developmental disability and substance use services.

Cultural Competency Plan Recommendations

1. Develop a community system of professional mental health, developmental disability and substance abuse care that responds to the clinical needs of those we serve in the context of their culture.
2. Adopt and promote the use of the fifteen National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) as created by the Office of Minority Health.
3. Provide educational workshops and training in addressing cultural competence in behavioral health agencies.
4. Foster and advocate for policies and practices that support adherence to federal laws related to cultural competence.
5. Partner with the Office of Minority Health and Health Disparities to add behavioral health as an indicator on its Racial and Ethnic Health Disparities in North Carolina Report Card.

6. Establish a Cultural Competence work group within the DMH/DD/SAS.
7. Develop a cultural competency training framework that provides the system a model which can be used to build and train MH/DD/SAS professionals.
8. Research and identify best practices effective in offering culturally diverse services.
9. Engage with community-based and faith-based organizations to foster trust and support for community education forums.
10. Ensure data collection efforts include demographic points specific to race, ethnicity, gender and disability.

Customer Service and Community Rights, and Community Engagement and Empowerment Teams

These teams' role is to support access to appropriate services, ensure rights protections in the community, and promote consumer empowerment and system advocacy. Staff include consumers and family members. They work to make it easy for consumers to share their concerns, answer their questions, help resolve their complaints, and process their appeals. There are two teams to assist consumers:

Community Engagement and Empowerment Team

* Keeps consumer, and family members and advocates actively involved in local and state policy development and planning.
* Ensures that consumer voice, input, and disability representation is included in building a better service system.
* Helps develop local grass roots advocacy and consumer groups.
* Provides support and assistance to the state and local Consumer and Family Advisory Committees (CFACs) to ensure empowerment and an informed system.

Customer Service and Community Rights Team

* Assists individuals and families with accessing public services by providing educational and system information.
* Provides a responsive system for complaints or concerns reported.
* Monitors community rights protections and health and safety through incident reporting improvement system.
* Provides a responsive system for the protection of rights when individuals are served in the community.
* Assists individuals and guardians with the appeal process for state-funded services
* Collects and reports aggregate complaint data.
* Tracks and manages efficacy of the response system for complaints and issues.
* Provides technical assistance to customer services representatives at the local and state levels
* Provides information about resources within the community.
* Coordinates technical assistance related to Medicaid billing, legal issues, and inquiries related to the NC Provider Network.
* Addresses complex issues between providers and LME-MCOs.
* Provides services similar to case management for individuals with complex needs and assists individuals in obtaining appropriate, quality services. This includes individuals in a hospital emergency room, transitioning from residential service, or individuals without appropriate connection to other services.
* Work with the State Coordinator for Children with Complex Mental Health and Intellectual/ Developmental Disabilities needs.

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We complete warm phone transfers when individuals are in crisis or we feel that there is a need to do so. We connect with a Licensed Clinician at the caller's LME/MCO to assure that a person in crisis receives needed assistance. If we receive a letter or e-mail (such as those sent to Asha) in which we are concerned about the safety of an individual, we ask the LME/MCO to have provider staff who are working with the individual to contact the individual. If there is no provider working with the individual, we ask the LME/MCO to request a well-check from the police.

Complaints and inquiries are received from the consumers, family members, providers, Governor's office, legislative offices, DHHS Secretary of Health and Human Services Office, DMH/DD/SAS Division Director's office, LME/MCO offices, community members and other stakeholders. We assist individuals with all aspects of requests from requests to access services, resolving complaints, facilitating services for individuals in transition from hospitals and other settings, resolving issues with providers, informing individuals and families about their rights, etc. We do our best to assist the caller or writer to receive information needed toward resolution, including using Google to find information that may not pertain to MH, IDD and/or SU services. In FY 2016-2017, our team addressed 417 complaints of the total of 5,751 independent inquiries (Complaints, Information/Referrals, Incident Reports and State-funded Appeals) received by our office. Data from our team is analyzed in a quarterly report.

Adverse Events and Overview of Incident Response and Improvement System (IRIS). IRIS is our electronic incident reporting system. Providers enter an incident report into the electronic system within 72 hours of learning of the incident. The categories of an incident are death, injury, restrictive interventions, medication error, allegations of abuse/neglect and exploitation, consumer behavior, suspension, expulsion and fire. Each incident is leveled between 1 and 3, based on severity. Level I incidents generally require first aid or less for services and Level II incidents generally require treatment beyond first aid and/or police involvement. Level II incidents also include deaths from natural causes or terminally illness. Level III incidents are the most serious and may result in permanent or psychological impairment, a threat to safety and/or result in a media contact. Deaths from suicide, homicide, violence or unknown causes are considered Level III. Once a provider enters an incident report, the report immediately is sent to the Host LME/MCO (county where individual is receiving services), home LME/MCO (where individual resides), and licensing agency of the facility (if service is a licensed facility). If the report is a Level III, the report is also submitted to the CSCR team and if it involves a death at a licensed facility as a result of suicide, homicide or violence, the report is also submitted to the NC Division of Health Service Regulation (DHSR) Complaint Intake Unit for review. If there is an allegation of abuse, neglect or exploitation by an unlicensed staff member, the report is also submitted to DHSR Health Care Personnel Registry for investigation.

If the report is a Level II, the LME/MCOs review these incidents to assure that appropriate agencies were notified agencies (including the local Department of Social Services and law enforcement) and efforts toward reduction/elimination of further incidents. If the report is a Level III, the LME/MCO and our CSCR team review to assure appropriate notification of agencies (including the local Department of Social Services and law enforcement), and any issues regarding health and safety are addressed as well as efforts toward reduction/elimination of further incidents.

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Quality Assurance/Quality Improvement

DMH/DD/SAS Internal QA/QI Structure

- The QM Steering Committee (QMSC) is charged with the overall success of the Division's quality management activities. QMSC oversees all quality management responsibilities in the Division and serves as the hub receiving information and recommendations from the Quality Cross-Functional Committees and Special Initiatives/Projects, and it serves as the link to other DHHS quality initiatives.
- Through Continuous Quality Improvement we identify and track critical outcomes and performance measures, which describe the health and functioning of the mental health and addiction systems. Our processes include:
  - Reviewing valid and reliable performance and outcome data
  - Determining significance of trends and patterns
  - Monitoring & Evaluating improvement initiatives
  - Raising the bar on measures when appropriate
  - Involvement of system participants and stakeholders
  - Contracts with LME/MCOs that include performance measure financial impact

LME/MCO QA/QI Monitoring

- The Administrative Function Indicators and standards are as follows:
  - Percent of calls abandoned (Standard – 5% or less)
  - Percent of calls answered within 30 seconds (Standard – 95% or higher)
  - Percent of psychiatric inpatient readmits assigned to Care Coordination (Standard – 85% or higher)
  - Percent of routine authorization requests processed in 14 days (Standard – 95% or higher)
  - Percent of expedited authorization requests processed in 3 days (Standard – 95% or higher)
  - Percent of claims processed within 30 days (Standard – 90% or higher)
  - Percent of complaints resolved in 30 days (Standard – 90% or higher)
    If an LME/MCO does not perform satisfactorily on any of the Administrative Function Indicators for three consecutive months, DHHS shall require the LME/MCO to submit a Plan of Correction within 30 days of notification and DMH/DD/SAS will provide technical assistance to the LME/MCO in the indicated area(s). Unsatisfactory performance is defined as not meeting the indicated standard.

- The Critical Performance Measure and standards are as follows:
  - Timely Access to Emergent Care within 2 hrs
  - Timely Access to Emergent Care within 2 hrs
  - Timely Access to Urgent Care within 2 days
  - Timely Access to Urgent Care within 2 days
  - Timely Access to Routine Care within 14 days
  - Timely Access to Routine Care within 14 days
  - Emergency Dept. Visits with Primary MH/IDD/SUD Diagnosis
  - Emergency Dept. Readmissions within 30 days
  - Follow-Up After Discharge: Community Crisis Svcs within 3 days
  - Follow-Up After Discharge: Community Crisis Svcs within 3 days
  - Follow-Up After Discharge: State Psychiatric Hospitals w/in 7 days
  - State Psychiatric Hospital Readmissions within 30 days

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- o Community MH Inpatient Readmissions within 30 days
- o Community MH Inpatient Readmissions within 30 days
- o Follow-Up After Discharge: Community Hospitals (MH) w/in 7 days
- o Follow-Up After Discharge: Community Hospitals (MH) w/in 7 days
- o Follow-Up After Discharge: State ADATC within 7 days
- o State ADATC Readmissions within 30 days
- o Community SUD Inpatient Readmissions within 30 days
- o Community SUD Inpatient Readmissions within 30 days
- o Follow-Up After Discharge: Community Hospitals (SUD) within 7 days
- o Follow-Up After Discharge: Community Hospitals (SUD) within 7 days
- o Medical Care Coordination - MH/IDD/SUD with health visit in last year
- o Medical Care Coordination - IDD with health visit in last year

Critical Performance Indicators are a designated subset of the Performance Measures.   These indicators are reported quarterly, with data that reflects monthly performance reported by the LME/MCO for measures that cannot be calculated by DHHS.

If an LME/MCO does not perform satisfactorily on any of the Critical Performance Indicators for three consecutive months, DHHS shall require the LME/MCO to submit a Plan of Correction within 30 days of notification and DMH/DD/SAS will provide technical assistance to the LME/MCO in the indicated area(s).

Unsatisfactory performance is defined as not meeting the Minimum Standards set by DMH/DD/SAS.

Indicators with a denominator less than ten shall be exempt from consideration of performance, with the exception of TCLI Critical Performance Indicators.
- Performance Measures w/ Penalties - beginning January 1, 2018, the following measures have a performance standard and corresponding penalty for each standard not met:
  - o Follow-Up After Discharge From Community Hospitals, State Psychiatric Hospitals, State ADATCs, and Detox/Facility Based Crisis Services For SUD Treatment
  - o Follow-Up After Discharge From Community Hospitals, State Psychiatric Hospitals, and Facility Based Crisis Services For Mental Health Treatment
  - o Number of Individuals Transitioned Into Supportive Housing (TCLI Population).
- Additional Performance Measures are based on the 2012 Healthcare Effectiveness Data and Information Set (HEDIS). The HEDIS measures were created through the National Committee for Quality Assurance's (NCQA) Committee on Performance Measurement. The performance measures will be reviewed in part by DHHS's External Quality Review contractor for the 1915 (b)(c) Medicaid Waiver.
  - o Penetration Rates:
  - o Adult MH
  - o Child MH
  - o Adult SUD
  - o Child SUD
  - o Adult I/DD
  - o Child I/DD
  - o Initiation of Substance Abuse Disorder Services
  - o Engagement in Substance Abuse Disorder Services
  - o Initiation for Persons receiving Mental Health Services
  - o Engagement for Persons Receiving Mental Health Services

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- o Timely Support for Persons with Intellectual or Developmental Disabilities
- o Short Term Care in State Psychiatric Hospitals
- o Admission Rate and Length of Stay in Community Hospitals for Mental Health Treatment
- o Transition within 90 days
- o Timely Quality of Life Survey Completion

Involvement of System Participants & Stakeholders in QA/QI

- • DMH/DD/SAS has a Quality Management staff that is embedded in the MH Planning Council. During the past year the DMH/DD/SAS sought involvement on the following topics:
  - o Apr 2016-   MH/SA Perception of Care Report
  - o Jun 2016-   Quality Monitoring
  - o Dec 2016-   Gaps Analysis
  - o Feb 2017-   Expenditures Reporting & Prevalence and Penetration Rates
  - o Apr 2017-   LME-MCO Quality Improvement Projects and Network Development Plans
  - o Jun 2017-   MH/SA Perception of Care Report
  - o Oct 2017-   Gaps and Needs Assessment Requirements Input

<u>North Carolina- Treatment Outcomes and Program Performance System (NC-TOPPS)</u>

NC-TOPPS began as a pilot study funded through a 1997 federal Center for Substance Abuse Treatment (CSAT) grant. North Carolina was one of 14 States that received the CSAT grant. This initiative was a partnership between the federal government and grantees to prepare States for development of a system to monitor and evaluate substance abuse treatment services. Based on information gathered during the pilot period lasting approximately two years, the State's Division of Mental Health, Developmental Disabilities and Substance Abuse ("the Division") transitioned the pilot program into an on-going data collection, feedback and planning system. NC-TOPPS later became a statewide system. Assessment instruments were built on research findings and field practice. Individual assessment items were discussed and agreed upon by participating programs and State substance abuse services staff.

In the spring of 2004, the Division decided to expand the NC-TOPPS web-based data collection system into the mental health arena. A participatory, collaborative and consensus-building process, similar to the process used for substance abuse assessments, was established involving mental health providers, Local Management Entities, researchers and consumers to develop and improve measures for mental health. On July 1, 2005, NC-TOPPS became the statewide method of collecting information necessary for accountability, quality improvement and tracking outcomes for consumers of the State's substance abuse and mental health treatment services.

As a web-based system, NC-TOPPS today can be used on most laptops, tablets and cell phones. Through regular consumer-to-clinician interviews during an episode of care at months 1, 3, 6, 12, 18, 24, etc., NC-TOPPS captures information about an individual's current situation, including such topics as symptoms, well-being, family and social relations, housing, employment, and legal system involvement. It also gathers consumers' perspectives on the system, including barriers to treatment, choice of providers, timeliness of care, and involvement in treatment planning.

NC-TOPPS gives providers information to develop person-centered plans and track goal attainment. It gives Local Management Entities/Managed Care Organizations information to evaluate consumer needs and improve

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local service quality. Furthermore, it gives State decision-makers, NC residents, and the federal government information to help evaluate and improve the effectiveness of the service system.

Interview information provides one method for collection of the Division's consumer functional outcomes data. Consumer functional outcomes data are the Division's source of information to monitor the impact of services. These data are also used to respond to departmental, legislative, and federal reporting requirements. NC-TOPPS accountability measures based on outcomes along with other performance measures are used for both the Community Mental Health Services Block Grant Program and the Substance Abuse Prevention and Treatment Block Grant Program reporting. In addition, the system provides data to meet SAMHSA's reporting requirements for the National Outcome Measures (NOMs) and the Treatment Episode Data System (TEDS) data as requested.

The NC-TOPPS system provides information on outcomes and program performance that can be used to improve service delivery and, ultimately, the quality of life for people with mental health and substance abuse needs who are served in the public service system.

- NC-TOPPS Links:
  - NC-TOPPS Login: https://nctopps.ncdmh.net/Nctopps2/Login.aspx
  - Public Dashboard: https://nctopps.ncdmh.net/ProviderQuery/Index.aspx
  - Website: https://www.ncdhhs.gov/providers/provider-info/mental-health/nc-treatment-outcomes-and-program-performance-system

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Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state?s behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state?s unique data system (including community-level data), as well as SAMHSA?s data sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, the annual **State and National Behavioral Health Barometers**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorderprevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the **National Survey of Substance Abuse Treatment Services** (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the **Behavioral Health Barometers**. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[1] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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[1] **http://www.healthypeople.gov/2020/default.aspx**

Footnotes:

Step 2: Identify the unmet service needs and critical gaps within the current system.

Responses to *Criterion 2: Mental Health System Data Epidemiology (Estimate of Prevalence and Quantitative Targets) and Criterion 4 (Targeted Services to Rural and Homeless, and Older populations)* and *Criterion 5: Management Systems* are included in our identification of unmet service needs and critical gaps within the current service system. Our primary data sources are the Uniform Reporting System (URS) tables required for the CMHS Block Grant, our paid claims data base for federal and state funds, the Client Data Warehouse (CDW), and the web-based NC Treatment and Outcomes Performance System (NC TOPPS). Local Management Entities/Managed Care Organizations and service providers provide information on client level demographic characteristics, claims for services, and clinical outcomes to the state data systems cited above.

Estimate of Prevalence and Quantitative Targets. Adults with serious mental illness (SMI) and children and youth with serious mental disorders (SED) constitute the populations of focus of the Community Mental Health Services Block Grant. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) uses prevalence estimates for adults with SMI and children with SED determined by the Federal Government and that are adjusted for state poverty thresholds by the National Research Institute (NRI) of the National Association of State Mental Health Directors (NASMHD) State Data Infrastructure Coordinating Center for the Center of Mental Health Services. About 5.4 percent of the state's adult population and 12.0 percent of children and youth have a diagnosable mental health disorder that meets the Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria accompanied by serious role impairment that has lasted for at least twelve months and puts the individual at risk for out-of-home placement.

With a population estimate of 10,146,788 residents for 2016, North Carolina has the ninth largest population among 50 states, ranking 14th in population change between 2010-2016 (https://www.census.gov/data/tables/2016/demo/popest/state-total.html). Adults make up about 77.3 percent (7,848,068) of the total population of which approximately 424,005 have serious mental illness based on the SMI prevalence estimate of 5.4 percent.
Children and youth make up close to a quarter (22.7%) of the whole population. Based on the prevalence estimate (12%) for the state, North Carolina had a total of 233,648, children and youth with SED in 2016 (**http://www.census.gov/popest/data/state/asrh/2014/index.html**).

Unmet service needs and critical gaps. The SMHA served a total of 223,845 individuals diagnosed with psychiatric disorders in community-based settings in SFY 2014 (https://www.samhsa.gov/data/sites/default/files/NorthCarolina.pdf). Of this number 123,034 met the criteria for SMI and 39,005 met the criteria for SED. Thus, the state treated only 29 percent of the estimated 424,005 adult North Carolinians estimated to have SMI and only 16.7 percent of the estimated 233,648 NC children and youth estimated to have SED.

Older populations. The U.S. Census Bureau estimates that nearly 23 percent of North Carolina's population will be over age 60 by the year 2030, an increase of more than 26 percent

from 2012. Of the state's residents, 35.1 percent are now over 50, 21.5 percent are over 60, 10.0 percent are over 70, and 3.6 percent are over 80 (https://www.census.gov/data/tables/2016/demo/popest/state-detail.html). The proportion of North Carolina's population that is 60 and older is growing more rapidly than other components of the population.

Older groups are largely underrepresented among adults served through DMHDDSAS, Individuals 65 and over comprise about 15.2 percent of the general adult population (**https://www.census.gov/data/tables/2016/demo/popest/state-detail.html**); however, only 3.2 percent of individuals served through the public mental health system were in this age group (https://www.samhsa.gov/data/sites/default/files/NorthCarolina.pdf). DMHDDSAS currently funds 18 Geriatric Adult Mental Health Specialty Teams to increase the ability of people with mental illness to live successfully in their communities. The team consists minimally of a therapist and a registered nurse, both with experience working with the population. The team provides training and consultation to staff working in adult care homes, home health care agencies, and senior centers as well as community organizations and program staff that support older adults with mental illness to remain in their community.

DMHDDSAS and the Division of Aging and Adult Services (DAAS) co-lead the NC Mental Health and Aging Coalition, the mission of which is to focus on the mental health needs and substance use of older adults, build community capacity, and support advocacy and action. In the past year, SAMHSA and the Administration on Aging sponsored a Regional Policy Academy focused on the issues and challenges around behavioral health for older adults. The NC Team that attended the academy consisted of professionals from DMHDDSAS, DAAS, and DMA who together developed a plan to bring awareness and education to community partners to begin conversations to address issues related to suicide, depression/anxiety, alcohol, and prescription and other drug use and misuse among older adults. DMHDDSAS has included a Peer Support Specialist Certificate opportunity to engage older adults in recovery from mental health issues to provide peer support and mentoring to their cohorts.

Rural populations. The Community Mental Health Services Block Grant provides services to adults with serious mental illness and co-occurring disorders and to children with

serious emotional disorders and co-occurring disorders who live in rural areas where close to one-fourth of the state's residents reside. The state has typically served more people with mental health disorders in rural areas. For instance, the State Mental Health Agency (SMHA) delivered mental health services to 344 adults per 10,000 and 304 children or youth per 10,000 residing in rural counties. About 266 adults per 10,000 and 293 children and youth per 10,000 were served in metropolitan areas in the same fiscal year. DMHDDSAS, in collaboration with the Medicaid agency, the Office of Rural Health and Community Care, and the Local Management Entities/Managed Care Organizations, have engaged in several efforts to increase access to mental health and substance abuse services throughout the state. These include the expansion of telepsychiatry services, walk-in centers, and mobile crisis teams. DMHDDSAS further has an ongoing contract with the School of Nursing in the University of North Carolina at Chapel Hill to provide tuition-assistance to psychiatric mental health nurse practitioners graduate students. In return for the funding, the students agree to find employment to serve consumers in underserved areas of the state. Recruitment and training of rural mental health professionals is also being addressed as part of the state's current workforce initiative.

Homeless populations. The NC Coalition to End Homelessness, a statewide non-profit organization, holds a point-in-time count of the homeless over a 24-hour period in the last week of January each year. Results for the 2017 count showed 10,683 people living in sheltered (emergency, seasonal, or transitional) and unsheltered settings, a decrease of 765 from the previous year. Of the homeless adults, 1837 had serious mental illness while 2343 had substance use disorder. A total of 416 had been discharged from a mental health hospital or a substance abuse program in the thirty days preceding the point-in-time count.
About 10 percent of homeless adults were veterans. Projects for Assistance in Transition from Homelessness (PATH), a federal grant program administered by the state, provides outreach to individuals who are homeless and who have mental illness or co-occurring mental and substance abuse disorders.

Needs of the military and veterans. In 2008 the Rand Center for Military Health and Policy Research published "Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery" that focused on post-traumatic stress disorder, major depression, and traumatic brain injury as the invisible wounds service men and women incurred because of war. The monograph included a report from a telephone survey of 1,695 individuals who had been previously-deployed in Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) that found mental and cognitive problems in about a third of the respondents with 11.1 percent having a mental health condition only (PTSD or depression, no TBI), 7.3 percent having a mental health condition combined with TBI, and 12.2 percent, having

TBI only.   PTSD, depression and TBI have immediate and long-term consequences for the individual, society, and the economy. And yet, close to 60 per cent of those with TBI had not been evaluated for their injury and only about 53 percent of those with PTSD or depression had gone to doctor or clinician for help. Confidentiality, availability of providers, and lack of evidence-based practices were cited as the most common barriers to treatment (**http://www.rand.org/content/dam/rand/pubs/monographs/2008/RAND_MG720.pdf**).

North Carolina is home to a large number of active military, National Guard and Reserves, veterans, and military families, ranking third in the country on this criterion. In a recent study, the NC Institute of Medicine noted that 35% of North Carolinians have some relationship to the military. The number of reserve component members in the state sum up to 22,000. A total 116,000 are in the active military, while a total of 766,000 are veterans, and 190,896 are dependents of service members. Forty-three percent of service member families include children and youth. Based on the estimates of 14 percent for PTSD, 14 percent for major depression and 18.5 percent for TBI established in the Rand study cited above, 107,240 would have PTSD, another 107,240 would have major depression and 141,710 would have TBI among the veteran population alone.

DMHDDSAS serves the needs of the military primarily through the NC Focus on Service Members, Veterans, and their Families, a project that it supports. NC Focus promotes evidence-based and best practices in the screening, assessment, and treatment of active duty, National Guard, reservists, and veterans who served in the military and their families.

Race/Ethnic Disparities. Blacks or African Americans are over-represented in the mental health public service delivery system, more so among children and youth than adults. Black or African American individuals constitute 22.2 percent of the North Carolina population and 31.8% of individuals served by the SMHA. Conversely, the Hispanic or Latino population currently constitutes 9.2 percent of the total population of North Carolinians and 4.7% of individuals served by the SMHA. North Carolina has one of the highest growth rates in Hispanic or Latino population in the nation. The growth of Hispanics or Latinos highlights a need for service providers to examine barriers that residents who are Hispanic may encounter when seeking services. Many area programs are attempting to hire Spanish speaking staff, but others still rely on using interpreters when providing services.

In summary, the CMHS Block Grant will continue to provide services to the populations identified by statute who continue to be in need of services. The grant will focus on serving (a) children and youth with Serious Emotional Disorders (SED) and their families and (b) adults with serious mental illnesses (SMI). It will also continue its focus on priority populations with or at risk for SED and SMI to which it is currently providing services using state and/or federal

funds. The state priority groups are the following:

- o For mental health
  - o those who are deaf and hard of hearing
  - o those who are homeless
  - o military veterans and their families
- o Co-occurring disorders
  - o Children and youth with co-occurring disorders
  - o Adults with co-occurring disorders

DMHDDSAS has submitted a grant application to SAMHSA for the SOC Expansion Planning Grant that will highlight the needs of American Indians/Alaska Natives, Hispanics or Latinos, military personnel (active, guard, and reserve and their families, LGBT (Lesbian, Gay, Bisexual, and Transgendered) populations and other un- or underserved populations, including the elderly).

DMHDDSAS, Local Management Entities, the NC Mental Health Planning and Advisory Council, Consumer and Family Advisory Committees, the NC Institute of Medicine task forces, and advocacy groups conducted surveys in 2010 to determine unmet service gaps and priorities in the public mental health and substance use service delivery system, the results of which fall into six themes that provided direction to the identification of unmet needs and the prioritization of planning activities. The themes are:

- *Long Term Supports for Independence and Recovery*, including emergency services, affordable medications, primary healthcare, housing, employment, and other supports for community living.
- *Quality and Accountability*, including comprehensive assessments, the use of evidence- based practices, performance tracking, and efficient data systems.
- *Workforce Development*, including provider trainings in core and specialty areas, especially from consumers' and families' perspectives, and residency rotations in mental health, substance abuse and developmental disabilities.
- *Expansion of Services*, particularly for rural areas, trauma- informed care, dual disability services, and community inpatient services.
- *Services for Vulnerable Populations*, including people who are deaf and hard of hearing, people undergoing transitions, very

young children and their families, women and girls, youth who are at high risk, people who are homeless, people with justice system involvement and people with chronic illnesses

- *Leadership and System Management*, including State and local disability-specific specialists, interagency collaboration and cooperation, use of effective funding policies, and support for consumers' participation in policy decisions.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #:	1
Priority Area:	Community Integration
Priority Type:	MHS
Population(s):	SMI, SED

Goal of the priority area:

1) Increase access to community-based services
2) Reduce need for inpatient care
3) Partner with people with mental health and co-occuring disorders to provide direction to the public service delivery system at the systemic and individual levels and to participate and guide treatment.

Objective:

Adults with serious mental illness, children and youth with serious emotional disorders, and people with substance use disorders and co-occurring disorders, can develop their full potential if they live with freedom and dignity in the least restrictive setting and in the community of their choice.

Strategies to attain the objective:

1) Enhance community based services, strengthen system of care for children with SED and co-occurring disorders and their families, ensure post discharge planning.
2) Planning efforts will focus on increasing the representation of consumers and their families in decision making bodies and the participation of consumers and their families in treatment planning.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number served in the community
Baseline Measurement:	160,000 individuals were served in the community.
First-year target/outcome measurement:	161,000 SMI adults and SED children served (SFY 2017)
Second-year target/outcome measurement:	162,000 SMI adults and SED children served (SFY 2018)

Data Source:

Medicaid, federal, state, and other paid claims

Description of Data:

Payments made to service providers for publicly funded community based mental health services

Data issues/caveats that affect outcome measures::

Managed care organizations are using LOCUS/CALOCUS scales to measure levels of care which would also have an impact on the way that SMI and SED will be defined.

Indicator #:	2
Indicator:	Reduced re-admissions to state psychiatric hospitals (30 days)
Baseline Measurement:	13.3 perecent were re-admitted to a state psychiatric hospital within 30 days of discharge.
First-year target/outcome measurement:	No more than 12.5 percent will be re-admitted to a state psychiatric hospital within 30 days after discharge.
Second-year target/outcome measurement:	No more than 12 percent will be re-admitted to a state psychiatric hospital within 30 days of discharge.

Data Source:

State hospital records

Description of Data:

The clinical record held within the state hospital setting will include a running record of hospital usage for an individual.

Data issues/caveats that affect outcome measures::

Indicator #:	3
Indicator:	Reduced re-admissions to state psychiatric hospitals (180 days)
Baseline Measurement:	15.6 percent were re-admitted to a state psychiatric hospital with 180 days after dischrge.
First-year target/outcome measurement:	No more tha 15 percent will be re-admitted to a state psychiatric hospital within 180 days of discharge.
Second-year target/outcome measurement:	No more than 14.5 percent will be re-admitted to a state psychiatric hospital within 180 days of discahrge.

Data Source:

State psychiatric hospital admission records

Description of Data:

State hospitals track admission patterns of each individual that utilizes the facility.

Data issues/caveats that affect outcome measures::

Indicator #:	4
Indicator:	The number/percent of consumers and their families in decision making bodies/advisory committees
Baseline Measurement:	Consumers and parents will be represented in at least 25 decision making bodies/advisory committees
First-year target/outcome measurement:	Consumers and parents were represented in 26 decision-making bodies/advisory committees.
Second-year target/outcome measurement:	Consumers and parents will be represented on at least 27 decision making bodies/advisory committees

Data Source:

Family and youth surveys

Description of Data:

Surveys of family and youth organizations on the State Collaborative

Data issues/caveats that affect outcome measures::

Sample will not be representative; data will be based on self reports.

Priority #:	2
Priority Area:	Recovery Support Services
Priority Type:	MHS
Population(s):	SMI, SED

Goal of the priority area:

To assist adults who have mental health and/or substance use problems, and children with SED and co-occurring disorders and their families to have a safe and stable home in a safe neighborhood, to have meaningful work, and to be a contributing member of society.

Objective:

Adults with serious mental illness, children and youth with serious emotional disorders, and people with substance use disorders and co-occurring disorders recover from the symptoms of mental illness and/or substance abuse id supported by a strong body of empirical evidence. Recovery support means partnering with people who have mental health and/or substance problems to provide direction to the public delivery system at the systemic and individual levels. SAMHSA has identified four elements- health, home, purpose, and community- that are essential to recovery. To facilitate and sustain recovery, people with mental illness and substance abuse need to have services and supports to be healthy, to have a safe and stable home in a safe neighborhood, to have meaningful work, and to be a contributing member of society.

Strategies to attain the objective:

Strengthening and developing supported employment, supportive housing, peer supports and recovery specialists, transition, maintenance and aftercare services that people with mental health, substance use problems and/or co-occurring disorders need to maintain their recovery and develop resiliency.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Proportion of adults reporting participation in treatment planning
Baseline Measurement:	83% of adults reported participating in their treatment plan
First-year target/outcome measurement:	83% of adults will report participating in their treatment plan
Second-year target/outcome measurement:	84% of adults will report participating in their treatment plan.

Data Source:

Mental Health Statistics Improvement Program (MHSIP) Perception of Care surveys (consumer satisfaction survey)

Description of Data:

Surveys of family and youth conducted by DMH/DD/SAS

Data issues/caveats that affect outcome measures::

Sample is not representative; data are based on self-reports

Indicator #:	2
Indicator:	Proportion of families/guardians reporting participation in their children's treatment
Baseline Measurement:	81% of families/guardians reported participating in their children's treatment plan
First-year target/outcome measurement:	At least 82% of families/guardians will report participating in their children's treatment plan.
Second-year target/outcome measurement:	At least 83% of families/guardians will report participating in their children's treatment plan.

Data Source:

Mental Health Statistics Improvement Program (MHSIP) Perception of Care surveys (consumer satisfaction survey)

Description of Data:

Surveys of family and youth conducted by DMH/DD/SAS

Data issues/caveats that affect outcome measures::

Sample is not representative; data are based on self reports.

Indicator #:	3

Indicator:	Proportion of adult consumers receiving supported employment (long term support, supported employment group, supported employment individual)
Baseline Measurement:	A total of 350 adult consumers received supported employment
First-year target/outcome measurement:	At least 375 adult consumers will receive supported employment.
Second-year target/outcome measurement:	At least 400 adult consumers will receive supported employment

Data Source:

Medicaid, federal, state and other paid claims

Description of Data:

Payments made to service providers for publicly funded community based mental healths services

Data issues/caveats that affect outcome measures::

Indicator #:	4
Indicator:	Number of adults consumers receiving residential or living supports in the community (family living, group living, home supports, independent living, residential supports).
Baseline Measurement:	A total of 1,250 adult consumers received residential or living supports in the community.
First-year target/outcome measurement:	A total of 1,260 adult consumers will receive residnetial or living supports
Second-year target/outcome measurement:	At least 1275 adult consumers will receive residential or living supports

Data Source:

Medicaid, federal, state or other paid claims

Description of Data:

Payments made to service providers for publicly funded community based mental health services

Data issues/caveats that affect outcome measures::

Priority #:	3
Priority Area:	Primary and Behavioral Health Integrated Health Care
Priority Type:	MHS
Population(s):	SMI, SED

Goal of the priority area:

To address the primary health care needs of adults with SMI and children with SED.

Objective:

People with mental illness have morbidity rates that are higher than those of the general population. Their lifespan is also considerably shorter. Analyses of the NC Mental Health Statistics Improvement Program (MHSIP) perception of care surveys that now include health questions show higher prevalence of asthma, diabetes, and cardiovascular disorders among individuals with psychiatric and substance use disorders compared to the general populations as measured by the NC Behavioral Risk Factors Surveillance Surveys (NC BRFSS). The focus of planning activities for this priority will be two-pronged:(1) Treatment- where the individuals with mental health and substance use issues are treated for chroinc illness and where people with chronic illnesses are treated for mental health and substance use issues; and (2) prevention- where healthy lifestyles are promoted and the effects of medication are monitored for their physical and other side effects.

Strategies to attain the objective:

Support the promotion of health lifestyles and manage chronic conditions common to adults with SMI and children with SED.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of adult consumers in wellness education programs
Baseline Measurement:	30 adult consumers received wellness education
First-year target/outcome measurement:	At least 40 adult consumers will receive wellness education
Second-year target/outcome measurement:	At least 50 adult consumers will receive wellness education

Data Source:

Medicaid, federal, state, and other paid claims

Description of Data:

Payments made to service providers for publicly funded community based mental health services

Data issues/caveats that affect outcome measures::

Managed Care Organizations are using LOCUS/CALOCUS to measures level of care

Indicator #:	2
Indicator:	Number of adult consumers with SMI and youth with SED receiving tobacco cessation counseling
Baseline Measurement:	A total of 248 adult consumers with SMI and children with SED received tobacco cessation counseling
First-year target/outcome measurement:	At least 350 adults with SMI and children with SED will receive tobacco cessation counseling
Second-year target/outcome measurement:	At least 500 adults with SMI and children with SED will receive tobacco cessation counseling

Data Source:

Medicaid, federal, state, other paid claims

Description of Data:

Payments made to service providers for publicly funded community based mental health services

Data issues/caveats that affect outcome measures::

Managed Care Organizations are using LOCUS/CALOCUS scales to measure levels of care

Priority #:	4
Priority Area:	Mental Health and Substance Use Services for the military and their families.
Priority Type:	MHS
Population(s):	SMI, SED

Goal of the priority area:

To address the unmet needs of the military and their families through increased education, prevention, outreach, identification, engagement coordination, and delivery of behavioral health services.

Objective:

North Carolina is home to a large number of active military, National Guard and Reserves, veterans, and military families, ranking third in the country on this criterion. In a recent study, the NC Institute of Medicine noted that 35% of North Carolinians have some relationship to the military. The number of reserve component members in the state sum up to 22,000.

A total of 116,000 are in the active military, while a total of 766,000 are veterans, and 190,896 are dependents of service members. Forty-three percent of service member families include children and youth. Based on the estimates of 14 percent for PTSD, 14 percent for major depression and 18.5 percent for TBI established in the Rand study cited earlier, 107,240 would have PTSD, another 107,240 would have major depression and 141,710 would have TBI among the veteran population alone.

Strategies to attain the objective:

Planning will revolve around training, access to care in integrated practices, school settings, and third party payment.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of veterans served through DMD/DD/SAS
Baseline Measurement:	A total of 2,717 veterans (out of 215,643 individuals with mental illness served through DMH/DD/SAS) received mental health services
First-year target/outcome measurement:	At least 2,717 veterans will receive mental health services
Second-year target/outcome measurement:	At least 2,717 veterans will receive mental health services

Data Source:

Client Data Warehouse

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #:	5
Priority Area:	Services to Juveniles with SED and Adults with SMI who are involved with the Juvenile and Criminal Justice System.
Priority Type:	MHS
Population(s):	SMI, SED

Goal of the priority area:

Address the needs of people with mental disorders, substance use disorders, co-occurring disorders, or a history of trauma in the criminal and juvenile justice systems.

Objective:

Studies show that youth with SED and adults with SMI and people with SUD or co-occurring disorders are at high risk for involvement with the law. There is a need to increase the availability of, access to, and effectiveness of community-based interventions and treatments for people who are involved with the criminal justice system so that they do not end up in correctional facilities

Strategies to attain the objective:

Continue collaboration and planning activities with the Department of Correction and Administrative Office of the Courts to improve services and maximize the use of resources for justice involved people with substance use and mental health problems.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Numbers of youth and adults involved with the justice system who are served in the community
Baseline Measurement:	16,301 adult individuals involved with the justice system were served in the community by TASC. 3,256 youth involved with the justice system were served in the community through Juvenile Justice Partnerships.
First-year target/outcome measurement:	At least 16,400 adults involved in justice system will be served in the community by TASC. At least 3,200 youth involved with the justice system will be served by Juvenile Justice Partnerships.
Second-year target/outcome measurement:	At least 16,500 adults involved with the justice system will be served in the community by TASC. At least 3,200 youth involved in the justice system will be served by Juvenile Justice Partnerships.

Data Source:

NC Treatment and Outcomes Program Performance System (NC TOPPS)

Description of Data:

Data issues/caveats that affect outcome measures::

The SMHA and and SSA are currently merging Managed Care Organization which will result in changes to the provider networks serving these consumers.

Priority #:   6

Priority Area: Trauma Informed Care and other Evidence Based Services

Priority Type: MHS

Population(s):   SMI, SED

Goal of the priority area:

To increase the use of Evidence Based Practices

Objective:

Trauma is a widespread, harmful, and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war, and other harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of children, youth and adults receiving treatment for mental and substance use disorders. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery.
Research shows that adults with mental illness and substance use or co-occurring disorders and children and youth with SED and co-occurring disorders recover better if evidence-based practices are used in their treatment

Strategies to attain the objective:

Promoting training on trauma specific interventions and other evidence based practices.

┌─ **Annual Performance Indicators to measure goal success** ─────────────────────

Indicator #:   1

Indicator: Proportion of adult consumers served by ACT

Baseline Measurement: A total of 6.172 adults received ACT services

First-year target/outcome measurement: At least 6,200 adults with SMI will receive ACT services

Second-year target/outcome measurement: At least 6,250 adults with SMI will receive ACT services

Data Source:

Medicaid, federal, state, and other paid claims

Description of Data:

Payments made to service providers for publicly funded community based mental health services

Data issues/caveats that affect outcome measures::

Managed Care Organizations are currently merging and it could impact on submission of claims

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Indicator #:   2

Indicator: Proportion of child/youth consumers served with MST

Baseline Measurement: A total of 1,290 children/youth served received MST.

First-year target/outcome measurement: At least 1,290 children/youth with SED wil receive MST

Second-year target/outcome measurement: At least 1,300 children/youth with SED will receive MST

Data Source:

Medicaid, federal, state, and other paid claims

Description of Data:

Payments made to service providers for publicly funded community based mental health services

Data issues/caveats that affect outcome measures::

Manged care organizations currently merging which could impact submission of claims.

Indicator #:	3
Indicator:	Proportion of child/youth consumers with Therapeutic Foster Care
Baseline Measurement:	A total of 3,758 children/youth with SED received TFC
First-year target/outcome measurement:	At least 3,800 children/youth with SED will receive TFC
Second-year target/outcome measurement:	At least 3,850 children/youth with SED will receive TFC

Data Source:

Medicaid, federal, state, and other paid claims.

Description of Data:

Payments made to service providers for publicly funded community based mental health services

Data issues/caveats that affect outcome measures::

Managed Care Organizations are currently merging and it could impact submission of claims.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017   Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
3. Tuberculosis Services							
4. Early Intervention Services for HIV							
5. State Hospital			$0	$0	$0	$0	$0
6. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$18,593,939	$0	$0	$0	$0	$0
8. Mental Health Primary[*]		$0	$0	$0	$0	$0	$0
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)[**]		$2,255,218	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$400,000	$0	$0	$0	$0	$0
11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)	$0	$21,249,157	$0	$0	$0	$0	$0

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 7/1/2017   Planning Period End Date: 6/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems	$116,294			
2. Infrastructure Support				
3. Partnerships, community outreach, and needs assessment	$497,386			
4. Planning Council Activities (MHBG required, SABG optional)	$5,000			
5. Quality Assurance and Improvement				
6. Research and Evaluation				
7. Training and Education	$684,346			
8. Total	**$1,303,026**	**$0**	**$0**	**$0**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question
1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[33] Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[34] and ACOs[35] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[41] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

   The SAMHSA-HRSA framework conceptualizes physical and behavioral health integration as a continuum of six levels within three categories: coordinated care, co-located care, and integrated practice structures. In coordinated care, collaboration can be described as minimal, where patients are merely referred to another setting (level 1) or basic where primary and behavioral health care providers share and communicate with each other about them (level 2). In co-located care, providers serve patients in the same site with regular communication about their shared patients, but have different treatment plans for their patients (level 3). Level 4 of co-located care has a closer collaboration between providers with records shared between them. The levels of integrated care are characterized by close collaboration (Level 5) for shared patients, but separate treatment plans still exist for some patients. Full collaboration occurs in Level 6, for all, patients; both types of providers develop the treatment plan at this level (https://www.milbank.org/wp-content/uploads/2016/05/Evolving-Models-of-BHI.pdf).

   Integrated activities in the state can be found at all levels. In 2009, then Governor Perdue identified integrated behavioral health care as a priority in her administration and indicated the establishment of a "medical home" as an essential component of an effective mental health system citing Community Care of North Carolina (CCNC) as a model. In 2010, the state Medicaid agency - the Division of Medical Assistance (DMA) - approved the establishment of the Behavioral Health Initiative (BHI) to support the integration of primary and behavioral health care cares in 1,400 primary care practices serving more than a million Medicaid patients. Medicaid-eligible patients with mild to moderate behavioral health problems are served in the primary care practices that have been identified as their medical homes by medical providers who have been trained in the use of brief intervention techniques and motivational interviewing while those with more severe and persistent problems are referred to specialty clinics for behavioral health services. CCNC has developed a sophisticated system that allows the sharing of records by both primary and behavioral health care providers to facilitate care coordination. It further has an informatics system that uses performance measurement and feedback to improve quality of care while controlling costs. The Division of Mental Health, Developmental

Disabilities, and Substance Abuse Services (DMHDDSAS) – the SMHA and SSA – closely collaborate with CCNC for the coordinated treatment of individuals with the most severe and persistent mental health disorders.

Providers awarded funding by federal agencies such as SAMHSA and HRSA and by private local institutions such as the Kate B. Reynolds Charitable Trust and Duke Endowment offer integrated care through the co-location of a medical provider at a specialty clinic or a behavioral health care provider at a medical facility. For instance, the recently-concluded SAMHSA-funded NC Screening, Brief Intervention, and Referral (SBIRT) funded a licensed clinician (often dually-licensed for mental health and chemical addiction) to screen and provide brief intervention and treatment to patients coming in for their annual health visit who met the threshold for risky alcohol and drug use. Carr Mill Clinic, a behavioral health care provider has a primary care family physician on its staff funded by a grant from the Duke Endowment. Some schools and community centers also practice integrated care through the co-location of primary and behavioral health care providers.

The state aspires towards the full integration of primary and behavioral health care for individuals with mental health and substance use disorders (Level 6). But for the most part, most integrated activities still occur at the basic level of integration (Level 2). Clinics or practices that have received funding for integrated care have advanced to higher levels where collaboration and care coordination are more developed.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

The state provides services and supports towards integrated care for individuals and families with co-occurring mental and substance use disorders through federal funds (i.e., Medicaid, Block Grant, and Discretionary Grants) and state funds. Clinical Coverage Policy 8-C requires that all comprehensive clinical assessments include information on an individual's chronological general and medical health history and current issues, as well as current medications for physical conditions. These assessment requirements are applicable for all consumers and adherence is reviewed and monitored annually through block grant monitoring reviews. Additionally, Evaluation and Management codes have been approved by the Division that allow for various levels and types of health screening for many years.

North Carolina recently completed a no cost extension for its Certified Community Behavioral Health Clinic (CCBHC) grant. Although we were not selected as a demonstration site, over 60 provider agencies submitted requests to participate in the certification process. As stated in the first response, many demonstrated implementation of a number of physical health component screenings as part of their intake process.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?   ○ Yes ◉ No

and Medicaid?   ◉ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?
LME/MCO Network

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?   ◉ Yes ○ No

6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education   ◉ Yes ○ No

b) Health risks such as

    i) heart disease   ◉ Yes ○ No

    ii) hypertension   ◉ Yes ○ No

    viii) high cholesterol   ◉ Yes ○ No

    ix) diabetes   ◉ Yes ○ No

c) Recovery supports   ○ Yes ◉ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?   ◉ Yes ○ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?   ○ Yes ◉ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

In 2015, Mental Health America, published a report "Parity or Disparity: The State of Mental Health in America" that ranked states on the basis of the prevalence of mental illness and access to care with higher rankings indicating lower prevalence and higher access to care. North Carolina was ranked as 18th in the country (with a ranking of 11th for adults, and 30th for youth).

The major issues or problems related to the implementation and enforcement of parity provisions that the state is facing are related to (1) the deficit of providers for mental health, substance use, and co-occurring disorders in the state, (2) the absence or inadequacy of information about parity provisions, and (3) the stigma related to mental health and substance use disorders that prevent many people from seeking treatment or help for their problems.

10.   Does the state have any activities related to this section that you would like to highlight?

The state has a number of innovative integrated care projects. Integrated care is one of the priorities of the 1115 demonstration program.

Please indicate areas of technical assistance needed related to this section

Technical assistance related to this area would be development of payment models or reimbursement for integrated care.

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[45], **Healthy People, 2020**[46], **National Stakeholder Strategy for Achieving Health Equity**[47], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[48].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[51]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

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[45] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[46] http://www.healthypeople.gov/2020/default.aspx

[47] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[48] http://www.thinkculturalhealth.hhs.gov

[49] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[50] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?

    a) Race   ○ Yes ○ No

    b) Ethnicity   ○ Yes ○ No

    c) Gender   ○ Yes ○ No

    d) Sexual orientation   ○ Yes ○ No

    e) Gender identity   ○ Yes ○ No

    f) Age   ○ Yes ○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?   ○ Yes ○ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?   ○ Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?   ○ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard?   ○ Yes ○ No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care?   ○ Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight?

    Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[57] are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[58] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

[52] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[53] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[54] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[55] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[56] **http://psychiatryonline.org/**

[57] **http://store.samhsa.gov**

[58] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1.   Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?   ○ Yes   ○ No

2.   Which value based purchasing strategies do you use in your state (check all that apply):

a)   ☐   Leadership support, including investment of human and financial resources.

b)   ☐   Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

c)   ☐   Use of financial and non-financial incentives for providers or consumers.

d)   ☐   Provider involvement in planning value-based purchasing.

e)   ☐   Use of accurate and reliable measures of quality in payment arrangements.

f)   ☐   Quality measures focus on consumer outcomes rather than care processes.

g)   ☐   Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

h)   ☐   The state has an evaluation plan to assess the impact of its purchasing decisions.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?   ○ Yes ● No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI?   ● Yes ○ No

> If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.
>
> North Carolina is currently providing services through the Coordinated Specialty Care (CSC) Program – NAVIGATE model North Carolina currently allocates funds for 3 CSC sites. Two sites have been in operation since 2015. A third site was funded in January 2017 and will begin to accept clients in July 2017.
> • Funds are allocated to Alliance Behavioral Healthcare MCO for a contract with the University of North Carolina Department of Psychiatry, Center of Excellence for a program in Raleigh, North Carolina
> • Funds are allocated to Trillium Health Resources MCO for a contract with RHA, Inc. for a program in Wilmington, North Carolina
> • Funds are allocated to Cardinal Innovations Healthcare Solutions for a contract with Carolinas Healthcare System for a program in Charlotte, North Carolina

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

> CSC Programs in North Carolina bill Medicaid for covered services and are required to meet all Medicaid Billing requirements. This includes development of individualized person centered plans.
> A focus of CSC services at all sites is personal recovery from the patient's perspective.
>
> All three funded sites use the database developed by the NC EPI-TA program for data collection that provides individual client and aggregate data. The outcome database questions used by all programs reflect the process of recovery framed in the biomedical model (reductions in symptoms, improved social and vocational functions), the person model (social connectedness, hope, identity, meaningful life, empowerment), and the impact on others (resource utilization, disability, family). The questions are meant

to be clinically meaningful and to be utilized as part of routine clinical practice. The patient self-report measures are meant to be reviewed during a patient visits and the information used to the guide the intervention in real time. Patients self report on symptoms at each visit. A program Satisfaction Survey is completed quarterly. Shared decision making is recognized as a key component of medical management of complex disorders. After medical provider visits patients rate the quality of the inter action with ColloRATE, a 3 item rating scale. Therapists complete a questionnaire on vocational function, arrests and housing. Medical Providers review the patient self-report of symptoms and evaluate symptom severity during their routine mental status exam. Data on metabolic risk factors including height, weight, blood pressure, HGA1c 9 diabetes screen and lipid panel is collected on a quarterly basis.

In addition to providing funding for three CSC sites, funding is provided to NC-EPI-TA program through the University of North Carolina at Chapel Hill Department of Psychiatry to provide technical assistance, consultation, training, database management and fidelity monitoring.
The NC-EPI-TA program provides services to the three sites and is also available for consultation to other providers in North Carolina who are interested in learning more about FEP and evidenced based practices.
The NC-EPI-TA program provides on-going webinars aimed to enhance clinician early recognition of early psychosis in their clinical practice. These webinars are produced through the Area Health Education Centers (AHEC) in North Carolina.

Announcements of trainings and webinars provided through SAMHSA, National Institute of Mental Health (NIMH), National Association of State Mental Health Directors (NASMHPD) and the Prodrome and Early Psychosis Program Network (PEPPNET) are disseminated to providers and the primary staff at the LME/MCOs for the three funded sites.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? ⦿ Yes ◯ No

5. Does the state collect data specifically related to ESMI? ⦿ Yes ◯ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ⦿ Yes ◯ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

As noted in question #2, North Carolina is currently providing services through the Coordinated Specialty Care (CSC) Program – NAVIGATE model. NAVIGATE is a comprehensive team based approach designed to provide early and effective treatment to individuals who have experienced a first episode of psychosis. The NAVIGATE CSC treatment model was developed by the RAISE Early Treatment Program and was one of two CSC models tested as part of the RAISE research study.
In addition to the required functions which include assertive outreach and engagement, medication management, family therapy and education, individual therapy, supportive employment and education and case management, North Carolina requires that each CSC site include a Peer Support Specialist as part of the team. Peer support has been found to be a valuable component for CSC programs.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

North Carolina plans to continue to implement the following CSC sites:
• Alliance Behavioral Healthcare MCO for a contract with the University Of North Carolina Department Of Psychiatry, Center of Excellence for the Wake OASIS program located in Raleigh, North Carolina.
• Trillium Health Resources MCO for a contract with RHA, Inc. for the SHORE program located in Wilmington, North Carolina
• Cardinal Innovations Healthcare Solutions for a contract with Carolinas Healthcare System for the Eagle program located in Charlotte, North Carolina

In addition to the three CSC sites, North Carolina contracts directly with the University Of North Carolina Department Of Psychiatry for the North Carolina EPI –TA program for database development and management, technical assistance, clinical consultation and fidelity monitoring. Specific activities of this program are outlined in question #s3 and 6.
The Fidelity Monitoring Tool has been reviewed with all sites but this will be the first year that the EPI-TA program will rate the programs using the tool. Following a review the results will be discussed with each site and feedback solicited on both the usefulness of the tool and the process. The review will identify areas that need to be addressed by the programs and additional technical assistance needed that is specific to their site.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

The NC EPI-TA program developed and maintains the database base for all CSC programs. Measure selection for EPI-NC assessment is based on 1) clinical utility and administrative utility, 2) reliability and validity, and 3) feasibility. Measure selection was to a large extent influenced by the expert consensus panel organized by a collaboration between NIMH and the PhenX project. Please refer to question #3 for an overview of the database. Specific measures include:

Measure Rationale for Measure Clinical Utility/Administrative Utility
Mental Health Statistics Improvement Program (MHSIP) Consumer Survey sections:
• Educational Status
• Current employment
• Current school

• Arrests

• Substance use

• Program satisfaction The Center for Mental Health Services (part of SAMHSA) requires the MHSIP for grant-funded programs, as a national benchmark. We collect data for all of the domains covered in the MHSIP. We use the MHSIP sections listed (to the left), modified to collect information on social interactions via electronic communications as well as in-person. • Social and vocational function are explicit targets of early intervention programs, as part of the biomedical model of recovery.

• Arrests are an expensive aspect of service utilization and thus are important to the State.

• Substance use may be a barrier to recovery.

• Program satisfaction includes the patient's sense of whether program staff have a collaborative stance, are culturally sensitive, whether there were financial barriers to care, and overall program satisfaction. These are important to program administrators. Colorado Symptom Index Measures patient self-report of symptoms including mood, delusions, hallucinations, thought process, suicidal and homicidal thoughts. Self-reported reduction in symptom frequency is relevant to the biomedical model of recovery. Questionnaire about the Process of Recovery This scale was developed as a collaboration between persons with psychosis, their clinicians, and researchers to evaluate key aspects of recovery: connectedness, hope, identity, meaning, and empowerment. Measures interpersonal aspects of recovery from psychosis.

ColloboRATE Evaluates medical provider's use of shared decision making approach, shown to enhance engagement. Patient report, 3-items that ask about their perception of the medical provider's collaborative stance.

Brief Psychiatric Rating Scale This is collected by the medical provider, and covers key target symptoms including mood, delusions, and hallucinations, thought process, suicidal and homicidal thoughts. Clinician-rated symptom severity may differ from self-report, and is relevant to the biomedical model of recovery.

10.   Please list the diagnostic categories identified for your state's ESMI programs.

CSC Programs in North Carolina serve individuals ages 15-30 who have a diagnosis of schizophrenia spectrum illness and other psychotic disorders who have experienced a first episode of psychosis within 3 years since the onset of the psychotic illness. The following individuals are excluded:

• Individuals diagnosed with a pervasive developmental disorder or autism spectrum disorder

• Individual with an IQ of less than 70

• Individual diagnosed with an organic brain disorder

• Individual whose psychosis is secondary to substance use.

Does the state have any activities related to this section that you would like to highlight?

N/A

Please indicate areas of technical assistance needed related to this section.

We continue to have the challenge of the uncertainty in the amount of funding available through the set-aside from year to year. Sustainability of programs is an on-going issue.

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? ⦿ Yes ○ No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

The NC Mental Health Planning and Advisory Council in their review of data has noted related trends in the perception of care survey that will be monitored for further study and recommendations.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Person centered planning is based on a variety of approaches, values, principles or "tools" to organize and guide community change and life planning with people with disabilities, their families and friends. All approaches or "tools" have distinct practices, but share common beliefs, taking into careful consideration legislative requirements, new priorities that have emerged, innovative approaches that are available, and evaluative information that has provided new direction for the planning process.

For children, youth and famiiles, the SOC framework, including family driven, youth guided practices and culturally and linguistically responsive practices, is the foundation upon which Child and Family Team planning is based for person centered planning. Training is offered across the state to families and providers on CFT planning from a family and youth perspective through the NC Collaborative for Children, Youth and Families. The LME SOC Coordinators and Family Partners help prepare and support families and youth in the planning process.

4. Describe the person-centered planning process in your state.

Since the inception of the Person-Centered Plan (PCP) in 2006, the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services has supported and encouraged the utilization of person-centered planning and the professional development and growth of all people engaged in the process. Through ongoing evaluation of the PCP, the Division of MH/DD/SAS has monitored the achievement of objectives using quantifiable measures, assessed the effectiveness of particular interventions and policies, as well as monitored public opinion. Subsequently, the PCP format has been redeveloped over the last five years,Person centered planning is based on a variety of approaches, values, principles or "tools" to organize and guide community change and life planning with people with disabilities, their families and friends. All approaches or "tools" have distinct practices, but share common beliefs, taking into careful consideration legislative requirements, new priorities that have emerged, innovative approaches that are available, and evaluative information that has provided new direction for the planning process.

The Person-Centered planning process supports strengths and recovery and applies to everyone supported and served in the North Carolina Mental Health, Developmental Disabilities and Substance Abuse system. Person-centered planning provides for the individual with or the family of a person with a disability assuming an informed and in-command role for life planning, service, support and treatment options. The person with a disability, and his/her family, or the legally responsible person directs the process and shares authority and responsibility with system professionals about decisions made.

The policy of the NC Division of MH/DD/SAS is that the Person-Centered Plan (PCP) is the umbrella under which all planning for treatment, services and supports occurs. Person- centered planning begins with the identification of the reason the individual/family is requesting assistance. The plan focuses on the identification of the individual's/family's needs and desired life outcomes. This is not just a request for a specific service(s). The Qualified Professional responsible for the development of the PCP must assure that the plan captures all goals and objectives and outlines each team member's responsibilities within the plan. This plan is based on what is most important to and for the individual/family as identified by the person/family to whom the plan belongs and the people who know and care about the person. This planning approach therefore supports good action and crisis

planning. The plan captures long term and short term outcomes, goals and objectives, including detailed information regarding justification for continuation, modification or termination of a goal and it outlines each team members' responsibilities within the plan.

For children, youth and families, Child and Family Team planning occurs in developing the person centered plan and often in developing the IEP and/or 504 plans for children eligible under IDEA.

Does the state have any activities related to this section that you would like to highlight?

The SMHA working as a partner with the NC Collaborative for Children, Youth and Families will offer training for trainers, for providers, families and youth in Child and Family Team planning process during the next two years. Curriculum will be updated and informed by youth perspective.

The SMHA is exploring ways to increase consumer, family and youth skills in self-advocacy, WRAP and Futures planning.

The SMHA is invested in sustaining the development of Family Partner Coordinators, Family Partners, Youth Partners and Young Adult Partners working as peers and self-advocacy is vital to sustaining the strength of the SOC platform and interagency work on the individual and family and in the community, regionally and state at large.

Please indicate areas of technical assistance needed related to this section.

Integrating consumer, family and youth voice, partnership and peer health navigators core SOC in a privatized managed care arena.

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction?   ○ Yes ○ No

2. Are there any concretely planned initiatives in our state specific to self-direction?   ○ Yes ○ No

   If yes, describe the currently planned initiatives. In particular, please answer the following questions:

   a) How is this initiative financed:

   b) What are the eligibility criteria?

   c) How are budgets set, and what is the scope of the budget?

   d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

   e) What, if any, research and evaluation activities are connected to the initiative?

   f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?   ⦿ Yes ○ No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard?   ⦿ Yes ○ No

3. Does the state have any activites related to this section that you would like to highlight?

The Program Integrity procedures for NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) are incorporated into the Service System Integrity plan. It is the purpose of the Service System Integrity Plan to support compliance, proper expenditure and accountability within DMH/DD/SAS programs by ensuring that State and Block Grant dollars are utilized appropriately, in accordance with statutory and regulatory framework, and in support of programmatic goals. The Service System Integrity Plan promotes the following principles:
1. Promote a cost efficient and effective behavioral health care system.
2. Ensure adherence to statutory and regulatory standards and practices.
3. Develop and monitor communication methods, training and technical assistance regarding service system integrity.
4. Support appropriate strategies and approaches to carrying out effective Service System Integrity efforts.
5. Proactively recognize areas of risk that may adversely affect Service System Integrity and proactively address vulnerabilities.
6. Fair and reasonable enforcement of system integrity monitoring. Failure to comply with system integrity efforts may result in technical assistance, plans of correction or other actions.

Please indicate areas of technical assistance needed to this section

     N/A

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[59] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[59] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

    Does the state have any activites related to this section that you would like to highlight?

    Please indicate areas of technical assistance needed to this section

> **Footnotes:**

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The SMHA provides a comprehensive system of care to enable individuals that it serves to live in communities of their choice and avoid inpatient hospitalization and institutionalization to the greatest extent possible. The array of available services includes basic outpatient services (assessment, individual therapy, group therapy, family therapy), enhanced mental health and substance abuse services (community support team, intensive in-home outpatient therapy, comprehensive outpatient therapy, Substance Abuse Intensive Outpatient program, Substance Abuse Comprehensive Outpatient Treatment, Adolescent Day Treatment), opioid/medication assisted therapies, halfway house and supported housing services, Work First services and Treatment Accountability for Safer Communities (TASC) for people who have been in the correction system. In addition, mobile and walk-in crisis services, various levels of detoxification, residential, and inpatient treatment services are available throughout the state. The continuum of services further includes evidence-based practices that are in the state service definitions (specifications of the services that providers can be paid for with public funds) such as Therapeutic Foster Care, Multi-systemic Therapy, and Family Functional Therapy for children and youth and Assertive Community Treatment, Supported Housing, and Supported Employment for adults. Other evidence-based practices are offered under the intensive in-home services definition. For example, an ACT team may implement an integrated dual disorders treatment model to better serve individuals with co-occurring mental illness and addiction. Children and youth with complex co-occuring disorders have a reinforced network of supports for improved coordinated care that is currently under development.

Seeking Safety or trauma-informed cognitive behavioral therapies may be utilized under the SAIOP or SACOT service definition for those individuals who have experienced trauma in their lives. Local Management Entities/Managed Care Organizations have also developed and implemented, with DMHDDSAS approval, alternate service definitions such as peer and recovery supports, transition services, wellness, and living skills) to create a more robust continuum of care. The SMHA further coordinates Crisis Intervention Programs (CIT) that provide law enforcement officials with skills that enable them to de-escalate crisis among people with mental illness to divert them from incarceration. Tele-health is currently being utilized in areas that have shortages of therapists and/or psychiatrists. Community Prevention Technical Assistance Resources funded through the Substance Abuse Prevention and Treatment Block Grant, recently funded Cures grant in May 2017 and the State's Strategic Prevention Framework/State Incentive Grants, provide additional resources.

DMHDDSAS receives funds from the NC General Assembly for crisis services (mobile crisis teams, emergency department length of stay plan, walk-in crisis and psychiatric after-care, and crisis intervention teams) geared towards the reduction of hospitalization, the use of emergency department services, jail diversions among people with mental health and substance use disorders. These services are implemented by the DMHDDSAS in coordination with the LME/MCOs and community partners.

In addition to contracting with the 7 LME/MCOs for the delivery of the service array from prevention, early intervention, treatment and recovery services and supports, the Division also contracts with several other entities to address needs and gaps within the system. Following are some examples of those contracts:

• Governor's Institute on Substance Abuse – The primary objective of this contract is to increase access to and improve the quality of services provided in the state by: (1) expanding the use of evidence-based/best practices through the NC Practice Improvement Collaborative (NC PIC); (2) promoting the integration of behavioral healthcare with primary healthcare in two regions of North Carolina and the rest of the state; (3) improving physician understanding of addictions and mental illnesses; and (4) enhancing the quality of the workforce and provider agencies in the state, with a special emphasis on service members, veterans and their families. Both the Mental Health and Substance Abuse Block Grants support this work.

• NC State University, Center for Urban Affairs and Community Services – This contract provides for the management of the web-based Treatment and Outcomes Program Performance System (NC TOPPS) which allows Local Management Entities/Managed Care Organizations (LME/MCOs) and their contracted network service providers to submit initial, periodic updates and episode completion interview information for all consumers within specified substance abuse and mental health populations. Data entered into the system is then used in developing accountability measures for both the Mental Health and Substance Abuse Block Grants.

• University of North Carolina, School of Social Work, Behavioral Healthcare Resource Program - The primary goal of this contract is to increase access to and improve the quality of building resiliency, prevention, early intervention, treatment and recovery supports and services by: (1) expanding the use of prevention, early intervention, treatment and recovery support services for mental health and substance abuse that demonstrate success in improving outcomes and/or supporting recovery; (2) enhancing the quality of the workforce providing prevention, early intervention, treatment and recovery supports and services; (3) enhancing the ability of provider agencies to determine the ongoing effectiveness of building resiliency, prevention, early intervention, treatment and recovery support services; and (4) planning the implementation of new, expanded or enhanced services within the state. This work is supported by both the Mental Health and Substance Abuse Block Grants.

• Center for Child and Family Health – This Center is a collaborative coalition among the University of North Carolina in Chapel Hill, Duke University, North Carolina Central University and the National Center on Child Traumatic Stress Network.) The goal of this contract is to provide subject matter expertise to promote, inform and train the system in the use of evidenced based services and supports that are developmentally appropriate, address sexually reactive diagnosis and treatment, and trauma-informed care.

• National Alliance on Mental Illness North Carolina (NAMI NC) – This contract's purpose is to 1) provide youth, families and adult consumers, providers and community partners the knowledge and skills essential as stakeholders in sustaining an effective recovery oriented system of care; and 2) provide outreach to, promote awareness of, and access to participation in consumer, youth and family driven person centered planning and recovery oriented Mental Health, Intellectual and Developmental Disabilities, and Substance Abuse (MHDDSA) system of care in communities across North Carolina through an array of targeted evidenced informed consumer/family driven best practices for those most seriously in need of services and supports.

• North Carolina Families United and NC Youth MOVE (Motivating Others through Voices of Experience) – Mental Health Block Grant funds support NC Families United is to develop parent/family leadership partners to work with State and community partners for the purpose of building a strong system of care for children and youth experiencing mental health challenges and their families. This work includes recruiting, training and supporting Family Partners to work with the LME SOC Coordinators and School Child and Family Team Liaisons; actively promoting policies and procedures that serve the best interests of these children, youth, and their families through work with State and local entities; and actively promoting, modeling and adhering to the values and principles of System of Care, such as Child and Family Team training as part of person-centered planning.

• NC Youth MOVE (Motivating Others through Voices of Experience) - Mental Health Block Grant funds support NC Youth MOVE in providing youth leadership development training, mentoring, RENEW and Futures Planning, as part of person-centered planning, with youth/young adults ages 15-21 who have struggled with mental health and substance issues, including trauma-based experiences. The leadership series unites the voices of traditional and non-traditional leaders with lived experiences in various systems including mental health, juvenile justice, education, and child welfare. Youth leaders become engaged as peer to peer supports, participate in panels for outreach, education and to inform policy changes.

• REAL Crisis Intervention, Inc. – Mental Health Block Grant funds support the implementation of the NC Suicide Prevention Lifeline, part of the SAMHSA National Suicide Prevention Lifeline network, provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week at 1-800-273-8255. Staffed by trained professionals, the NC Suicide Prevention Lifeline responds to an average of 3,000 calls a day. On average, 234 referrals are made directly to the Mobile Crisis Teams, a part of the crisis service array implemented by the LME/MCOs statewide. The NC Suicide Prevention Lifeline is recognized nationally for excellence in the efficiency and volume of its call response and serves as one of eight approved VA Crisis Call Centers. Staffs are certified trainers for and provide Applied Suicide Intervention Skills (ASIST), a two-day course that trains community lay help givers – gatekeepers - about the risk for and signs of imminent suicide and how to prevent death by suicide from occurring.

The Division coordinates with the North Carolina National Guard, active duty, and US Veterans Affairs, Tricare, and the Citizen Soldier Support Program, as well as with the NC General Assembly, the Division of Vocational Rehabilitation Services, the Department of Correction, the Department of Public Instruction, the Department of Labor, the Governor's Institute, Area Health Education Programs, state universities, provider organizations, and faith- based organizations on various initiatives that address active duty military, veterans, National Guard Members, the Reserve, and family members of the military. The NC FOCUS on Service Members, Veterans, and their Families is a collaborative initiative of DMHDDSAS involving the state government, Veterans Affairs, the Department of Defense, and other organizations. Its mission is to promote best practices in the service of veterans who served in Operation Enduring Freedom/Operation Iraqi Freedom while creating a referral network of services for post- deployment readjustment assistance. The group developed resource materials for returning veterans with mental health needs, substance abuse disorders, traumatic brain injury, and homeless veterans and family members, including children of military families. Since this collaborative work began in 2008, efforts have spanned from combat veterans to all veterans, active duty as well as reservist and the National Guard.

The Division plans to build up its array of services to re-allocate resources to be more reflective of the effective behavioral health care system. Local Management Entities/Managed Care Organizations provide training to staff on cultural competence and responsiveness to the needs of minority and other underserved groups. Providers in the LME-MCO care networks are responsible for training their provider staff and implementing services that are culturally competent and responsive to build on strengths and meet individual and population based needs.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

a) Physical Health ○ Yes ⦿ No

b) Mental Health ⦿ Yes ○ No

c) Rehabilitation services ⦿ Yes ○ No

d) Employment services ⦿ Yes ○ No

e)	Housing services	⦿ Yes ○ No
f)	Educational Services	⦿ Yes ○ No
g)	Substance misuse prevention and SUD treatment services	⦿ Yes ○ No
h)	Medical and dental services	⦿ Yes ○ No
i)	Support services	⦿ Yes ○ No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	⦿ Yes ○ No
k)	Services for persons with co-occuring M/SUDs	⦿ Yes ○ No

Please describe as needed (for example, best practices, service needs, concerns, etc)

An overview and examples are provided in #1, 3 and 4 in this section.

In addition, the North Carolina Department of Health and Human Services (DHHS) is developing a Strategic Plan for the community and facility-based service system. This Strategic Plan will be presented to the North Carolina General Assembly in January 2018. There is particular interest in the following areas:
• Access to providers and services
• Affordability of providers and services
• Special populations & conditions (Veterans, Traumatic Brain Injuries, Autism, etc.)
• Navigating the system
• Improving quality of care
• Integration of physical and behavioral health

3. Describe your state's case management services

Currently seven Local Management Entities/Management Care Organizations provide care coordination for youth with special healthcare needs for the 100 counties of North Carolina. In addition, case management is embedded in residential and community based services. Intensive In-Home Services, day treatment, and Multi-Systemic Therapy all incorporate case management functions within each of these behavioral health clinical policy service definitions.

DMHDDSAS is piloting high fidelity wraparound with its intensive care coordination and family and youth peer support in four sites through a SAMHSA System of Care grant. In addition, DMHDDSAS is piloting high fidelity wraparound in one additional site with the intention of improved coordination between MCO care coordination for youth involved in juvenile justice and child welfare. This project is funded by the state legislature based on recommendations from a Governor's Task Force on Mental Health and Substance Use Disorders. The goal of these pilots is to learn how to effectively roll-out intensive care coordination and family/youth peer support (high fidelity wraparound) in order to scale up high fidelity wraparound across the state.

4. Describe activities intended to reduce hospitalizations and hospital stays.

• New clinical policy and service definitions for child facility based crisis services and state funding to start-up three child facility based crisis centers and state funded case management for adults in transitioning between care and community settings (a new pilot as a reult of the 2016 Governor's Task Force on Mental Health and Substance Abuse Services).
• Use of IVC designated behavioral health urgent care centers for children and adults.
• Current work with Division of Medical Assistance to revise the mobile crisis service definition to be more responsive to children, youth, and families. and more effective for adults.
• The above mentioned high fidelity wraparound pilots.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	424,005	121,054
2.Children with SED	233,648	17,031

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Data Source:
Population Data: NC Office of State Budget and Management (OSBM). Last updated: 10/8/15 Downloaded: 2/23/16 (https://ncosbm.s3.amazonaws.com/s3fs-public/demog/countytotals_singleage_2016.html)

MH Prevalence Rates*: Prevalence rates for children with Serious Emotional Disturbance (SED) and adults with Serious Mental Illness (SMI) in North Carolina were prepared for the Center for Mental Health Services (CMHS) by the National Association of State Mental Health Program Directors Research Institute (NRI) State Data Infrastructure Coordinating Center (SDICC), November 2016, for the Mental Health Block Grant.

? Children: URS Table 1b: Number of Children with Serious Emotional Disturbance, ages 9-17, by State, 2015. Note: 12% is the midpoint (11%-13%) for the LOF=60 range (SED with substantial functional impairment). The same rate was applied to children under age 9.
? Adults: URS Table 1a: Number of Persons with Serious Mental Illness, age 18 and older, by State, 2015 = 5.4%
* The number of persons with any mental illness is higher. In Sep 2011 the CDC estimated that about 25% of adults in the US have a mental illness. According to the National Surveys on Drug Use and Health, 2013 and 2014, published 12/16/15, Table 24, Any Mental Illness in the Past Year, by Age Group and State, 18.29% of adults in the US and 19.33% of adults in NC ages 18+ had any mental illness in the past year. (http://www.samhsa.gov/data/sites/default/files/NSDUHsaePercents2014.pdf).

According to the Centers For Disease Control and Prevention (CDC), 13% – 20% of children living in the United States ages 3-17 experience a mental disorder in a given year, and surveillance during 1994 – 2011 has shown the prevalence of these conditions to be increasing. (Mental Health Surveillance Among Children — United States, 2005 – 2011, May 17, 2013) (http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm).

The Any MI percents in the table above represent the upper limit of these ranges for children and adults.

Early Childhood MH (ECMH) Prevalence: According to NCIOM, Growing Up Well: Supporting Young Children's Social-Emotional Development and Mental Health in North Carolina (NCIOM, 2012), for early childhood, national research shows that between 10-14% of children ages 0-5 have mental health problems severe enough that they have trouble functioning. (http://www.nciom.org/wpcontent/uploads/2012/08/Chapter-11.pdf) The 12% in the table above represents the midpoint for this range.

Incidence (C) - informed by SFY16 URS Table 2B

Compiled By: NC DHHS DMH/DD/SAS QM Section

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	⦿ Yes ○ No
b)	Educational services, including services provided under IDE	⦿ Yes ○ No
c)	Juvenile justice services	⦿ Yes ○ No
d)	Substance misuse preventiion and SUD treatment services	⦿ Yes ○ No
e)	Health and mental health services	⦿ Yes ○ No
f)	Establishes defined geographic area for the provision of services of such system	⦿ Yes ○ No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

The Geriatric Mental Health Teams (GAST) provide training and support to staff working at community agencies, organizations and facilities providing services to older adults with mental health and substance use disorders. The training consists of mental health and substance use disorders, symptoms, and how to provide person-centered/trauma informed services. The GAST staff have begun to reach out to homeless service providers due to the increase in older adults who have become homeless.

The Projects for Assistance in Transition from Homelessness (PATH) is a federal grant providing a team of staff who provide outreach, engagement and case management services to adults with serious mental illness who are living outside or short term shelters. PATH Programs beginning in July 1, 2017 are located in Charlotte, Greensboro and Asheville with an additional program to be implemented in Raleigh. In FY2016, PATH Program staff provided 1737 individuals with outreach and enrolled 740 individuals.

Individuals living in rural communities have access to the NC Telepsychiatry Program with 30 current sites, 29 new sites in development, and 7 provider hubs.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

The Division of Mental Health/Developmental Disabilities/Substance Abuse Services sets up services through a sub-contract model. Seven Local Management Entities (LME/MCO) operate across the state and cover the needs of the consumers in the state's one hundred counties. Funding for services can come from a couple sources including Federal funding (including the MHBG) and state dollars. These are provided to the LME/MCO direct allocations. The LME/MCO in turn will then contract with providers in their areas for services needed. Te LME/MCO in contracting with DMH agrees to monitor the programs, evaluate the effectiveness of services, and ensure staff have the required credentials and training.

DMH/DD/SAS has two types of subrecipients – 1) the LME-MCOs (the local mental health authorities) and 2) non-profit organizations and other nongovernmental entities that are awarded financial assistance grants to carry out specific goals and objectives of the CMHSBG. Some of the activities funded by the CMHSBG focus on the advancement of evidence-based practices for individuals with SMI or SED through the provision of training, consultation and technical assistance; the provision of services to facilitate access to services to individuals with SMI or SED and their families; the collection of data and periodic interviews of consumers at various points in treatment from intake to the completion of services for National Outcomes Measures (NOMS) reporting; the provision of services to individuals that are deaf or hard-of-hearing; and technical assistance to the pilot sites that have implemented special programs for individuals experiencing a first episode psychosis.

Each year, a risk assessment is performed on each subrecipient to identify areas of vulnerability which might preclude the entity from meeting the compliance requirements of the grant. The level of risk determines the scope and intensity of monitoring. Both entities are monitored for compliance with the conditions of their contract. The LME-MCO liaisons and contract administrators have lead responsibility for ongoing programmatic monitoring of these entities. Such monitoring takes place via site visits, phone calls, e-mail communications, face-to-face meetings and a review of reports and data submitted by the subrecipient. Reports summarizing monitoring activities are submitted to the Policy and Audit Team each month as part of the division's subrecipient monitoring process.

Programmatic monitoring of the LME-MCOs occurs on two levels. The division assigns a liaison to each LME-MCO. The liaison monitors operations in the LME-MCO and compliance with the requirements in the performance contract, including issues that might arise involving access to mental health services and/or provider issues. The division also conducts an annual systems review of the LME-MCO which includes the CMHSBG. This is an on-site review of the LME-MCO and the providers of CMHSBG-funded services. The review includes a program review as well as a record review and looks at compliance with such requirements as eligibility, appropriate release and disclosure of information, service recipient and family participation in the treatment planning process, the promotion and implementation of evidence-based treatment services through the provision of provider training and monitoring, outreach and assertive engagement activities to individuals experiencing a first episode psychoses and their families, the provision of coordinated specialty care, the availability of crisis services and the LME-MCO support and oversight of services provided to individuals experiencing a first episode psychosis. The LME-MCOs are notified of the results of the annual systems review. Any plans of correction that result from the systems review are coordinated by the Policy and Audit Team in consultation with the Mental Health Section.

DMH/DD/SAS fiscally monitors the use of MHGB funding by the LME/MCO in multiple ways. In real time, there is monthly monitoring of the budget to actual use of funding by account/service; quarterly monitoring which reconciles LME MCO claims and self-reported expense data against actual payments to network providers. Retroactively, an annual audit is completed which includes all MHBG funding. This audit confirms utilization of funding as well as appropriate documentation after the close of timely filing and the certification of the LME/MCOs independent audits. Technical assistance is provided to LME MCOs as well as providers in the service delivery network whenever there are questions, concerns or findings.

Footnotes:

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1.   Has your state modified its CQI plan from FFY 2016-FFY 2017?   ○ Yes ○ No

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma [60] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?   ○ Yes ○ No

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?   ○ Yes ○ No

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?   ○ Yes ○ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?   ○ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight.

   Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

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[62] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder, **OJJDP Model Programs Guide**

[63] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? ○ Yes ○ No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? ○ Yes ○ No

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? ○ Yes ○ No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? ○ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight?

    Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? ○ Yes ○ No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? ○ Yes ○ No

3. Does the state purchase any of the following medication with block grant funds? ○ Yes ○ No

   a) ☐ Methadone
   b) ☐ Buprenophine, Buprenorphine/naloxone
   c) ☐ Disulfiram
   d) ☐ Acamprosate
   e) ☐ Naltrexone (oral, IM)
   f) ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? ○ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section.

   *Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Footnotes:

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[65],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

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[64]**http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[65]Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please respond to the following items:

1. Crisis Prevention and Early Intervention

   a) ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning

   b) ☐ Psychiatric Advance Directives

   c) ☐ Family Engagement

   d) ☐ Safety Planning

   e) ☐ Peer-Operated Warm Lines

   f) ☐ Peer-Run Crisis Respite Programs

   g) ☐ Suicide Prevention

2. Crisis Intervention/Stabilization

   a) ☐ Assessment/Triage (Living Room Model)

   b) ☐ Open Dialogue

   c) ☐ Crisis Residential/Respite

   d) ☐ Crisis Intervention Team/Law Enforcement

   e) ☐ Mobile Crisis Outreach

   f) ☐ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

   a) ☐ WRAP Post-Crisis

   b) ☐ Peer Support/Peer Bridgers

   c) ☐ Follow-up Outreach and Support

   d) ☐ Family-to-Family Engagement

     e) ☐   Connection to care coordination and follow-up clinical care for individuals in crisis

     f) ☐   Follow-up crisis engagement with families and involved community members

     g) ☐   Recovery community coaches/peer recovery coaches

     h) ☐   Recovery community organization

4.   Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;

- Recovery is person-driven;

- Recovery occurs via many pathways;

- Recovery is holistic;

- Recovery is supported by peers and allies;

- Recovery is supported through relationship and social networks;

- Recovery is culturally-based and influenced;

- Recovery is supported by addressing trauma;

- Recovery involves individuals, families, community strengths, and responsibility;

- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses

- Drop-in centers

- Recovery community centers

- Peer specialist

- Peer recovery coaching

- Peer wellness coaching

- Peer health navigators

- Family navigators/parent support partners/providers

- Peer-delivered motivational interviewing

- Peer-run respite services

- Peer-run crisis diversion services

- Telephone recovery checkups

- Warm lines

- Self-directed care

- Supportive housing models

- Evidenced-based supported employment

- Wellness Recovery Action Planning (WRAP)

- Whole Health Action Management (WHAM)

- Shared decision making

- Person-centered planning

- Self-care and wellness approaches

- Peer-run Seeking Safety groups/Wellness-based community campaign

- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1.   Does the state support recovery through any of the following:

a)   Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?   ⦿ Yes ○ No

b)   Required peer accreditation or certification?   ⦿ Yes ○ No

c)   Block grant funding of recovery support services.   ⦿ Yes ○ No

d)   Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

The State has legislation requiring consumer and family participation at the state and local levels. NC General Statute 122C-171 states that the Consumer and Family Advisory Committee (CFAC) shall be a self-governing and self-directed organization that advises the Department and the General Assembly on the planning and management of the State's public mental health, developmental disabilities, and substance abuse service system. The local CFAC is similarly required at each LME-MCO to review, comment on and monitor the implementation of the local business plan, identify service gaps and underserved populations, make recommendations regarding the service array and monitor the development of additional services, review and comment on the LME-MCO programs budget, participate in quality improvement measures and performance indicators, and submit to the State CFAC findings and recommendations regarding ways to improve the service delivery system.

In 2006, the State developed and implemented the North Carolina Certified Peer Support Specialist program to train and certify peer specialists. Currently, there are 2545 Certified Peer Support Specialists. A statewide Peer Support Services policy has been developed to ensure there is consistency across the state and it is recovery-focused and evidence-based. The stakeholder workgroup includes Certified Peer Support Specialists, peer support providers and other advocates. The work group is currently pilot-testing questions for a certification exam. The exam would be administered upon completion of peer support training and would be a requirement for certification.

In August 2012, the State signed a Settlement Agreement with the U.S. Department of Justice to develop and implement effective measures to prevent inappropriate institutionalization of individuals with serious mental illness/serious and persistent mental illness (SMI/SPMI). This includes the development of (1) permanent supportive housing, (2) transition protocols that include new "Transition Coordinators" and "In-Reach" staff providing engagement and linkage, and (3) community wrap-around supports and services such as Assertive Community Treatment (ACT), Peer Support, Supported Employment, and Tenancy Supports. The State is engaged in workgroups with stakeholders, including consumers and families, to receive input into the planning and revision processes to ensure services are recovery-focused and evidence-based. Peer Supports have been included in a variety of new functions, including as required staff on ACT and Individual Placement and Support (IPS) teams and as "Tenancy Support Specialists" to help people gain and maintain independent living skills in housing. Additionally, Certified Peer Support Specialists were hired as "In Reach" specialists for assertive engagement of individuals living in adult care homes and hospitals.

It is important to note that transition-age youth do not always relate to the idea of "recovery." The system and premise North Carolina embraces for children, youth and families is that of building resilience; some youth better identify with "pre-covery." To this end, the State funds North Carolina Families United (NCFU), the statewide family organization, to produce a training curriculum for families and service providers on how to implement a system of care and how to choose service providers for families with serious emotional disturbance (SED) and their families. With support from the block grant, NCFU has funded and trained Family Support Partners and specialists. NCFU works with NAMI in NC as well as community mental health associations and Family Support Network organizations to unify and strengthen work in this arena. Each of these entities along with other community and state organizations and agencies participate in the NC Collaborative for Children, Youth and Families, a statewide interagency forum for promoting the tenets and practices that further strengthen an effective system of care in North Carolina. Partnerships with families and youth leaders and those in transition are vital to the success and sustainability of a system of care that promotes strengths and builds resilient children, youth and families, especially those living with or at risk for experiencing behavioral health challenges.

The Center for Mental Health Services (CMHS) Block Grant mandates a Mental Health Planning Council, with half of

membership consisting of consumer and family representatives. The Council assists with formulating the CMHS Block Grant plan, including targets for the block grant indicators. The Council also reviews State plans and provides advice and recommendations to the State on service delivery issues. Many of the Planning Council's consumer and family representatives also sit on the SCFAC and LME-MCO CFACs.

The LME-MCOs have cultural competence policies and educate their providers, consumers, family members and LME-MCO staff on the importance of being culturally competent. The state provides technical assistance to LME-MCOs so that they can conduct Crisis Intervention Training (CIT) in their local communities to educate law enforcement officers. In addition, local CFAC members participate on the CIT panel presenting information relevant to living with persons with disabilities.

The State sponsors meetings that identify individual and family members' issues and needs regardingthe behavioral health system and develop a process for addressing these concerns. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) developed policy DO 112 Consumer and Family Member Volunteer Appointment to participate on DMH/DD/SAS workgroups and committees. This policy was developed so that all interested individuals have an equal opportunity to participate in the policy and decision-making bodies of the system. Notices for all volunteer opportunities are posted on the DMH/DD/SAS website and sent out to a mass mailing of all local CFACs, SCFAC and other grassroots organizations. Members of the Consumer Empowerment Team (CET) attend all local CFAC meetings and develop connections with individuals and local advocacy organizations in each of the catchment areas. CET members routinely inform their individual contacts of opportunities for inclusion and participation in the ongoing development and monitoring of mental health, developmental disability, and substance use service system.

2. Does the state measure the impact of your consumer and recovery community outreach activity?   ⦿ Yes ○ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

The State provides an expanding array of recovery-oriented, person-centered services available to adults with SMI/SPMI. Brief descriptions of these services are as follows:
Assertive Community Treatment (ACT) services consist of a community-based group of medical, behavioral health and rehabilitation professionals who use a team approach to meet the needs of an individual with SPMI. The ACT team addresses the breadth of an individual's needs and teaches psychiatric rehabilitation skills towards advancing personal recovery goals. The Certified Peer Support Specialist is a vital role on the team in promoting hope and self-determination that the individual can recover and regain meaningful roles and relationships in the community.
Community Support Team (CST) services consist of community-based mental health and substance abuse rehabilitation services and supports provided through a team approach to assist adults in achieving rehabilitative and recovery goals. CST is a 24/7 service that is designed to reduce presenting psychiatric or substance abuse symptoms and promote symptom stability, restore the individual's community living and interpersonal skills, provide first responder intervention and deescalate the current crisis, and ensure linkage to community services and resources.

Critical Time Intervention (CTI) is a time-limited, evidence-based practice that mobilizes support for the most vulnerable individuals during periods of transition. CTI promotes a focus on recovery and psychiatric rehabilitation, and bridges the gap between institutional living and community services by ensuring that a person has enduring ties to their community and support systems during these critical periods.

Peer Support Services (PSS), provided by Peer Support staff, offers structured and scheduled activities for adults with SMI or substance abuse disorders. Services focus on the acquisition, development, and expansion of rehabilitative skills needed to move forward in recovery. PSS emphasizes personal safety, self-worth, connection to the community, self-advocacy, personal fulfillment, and development of social supports and effective communication skills.

Focus on developing Family Partner Coordinators, Family Partners, Youth Partners and Young Adult Partners working as peers and self-advocacy is vital to sustaining the strength of the SOC platform and interagency work on the individual and family and in the community, regionally and state at large.

Individual Placement and Support- Supported Employment (IPS-SE) is an evidence-based practice that helps individuals with SMI work at regular jobs of their choosing. It is a person-centered, behavioral health service that assists in choosing, acquiring, and maintaining competitively paid employment in the community for individuals 16 years and older who are unemployed or who have intermittent or interrupted employment. Employment Peer Mentors offer hope and motivation by drawing from their lived experience and employment history to encourage individuals to seek and maintain employment, wellness, and community integration.
Transition Management Services (TMS) is a service provided to individuals participating in the Transition to Community Living Initiative (TCLI), and was formerly called Tenancy Support Team (TST). TMS focuses on increasing the individual's ability to live as independently as possible, manage their illness, and reestablish his or her community roles related to the following life domains: emotional, social, safety, housing, medical and health, educational, vocational and legal.

The State is in the process of implementing Peer Operated Respite Services (PORS), which would provide a temporary place for

individuals experiencing urgent emotional distress and/or an emergent crisis to voluntarily stay overnight for an average of 3-4 days. These support services will be provided in a home-like environment operated by a Consumer-Run Organization with Certified Peer Support Specialists. Through mutual relationship-building, the PORS will create an opportunity for individuals served to learn and grow with the staff and to find ways to support one another, and remain connected and engaged in their own lives and communities. DMH/DD/SAS expects that PORS will be an effective early intervention to prevent hospitalization and facilitate recovery.

Please refer to the Environmental Factors and Plan – First Episode Psychosis for more information on recovery-oriented services for children with SED.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Please Refer to the SUD Prevention and Treatment Block Grant Plan.

5. Does the state have any activities that it would like to highlight?

High Fidelity Wraparound

DMH/DD/SAS was the recipient of a four-year System of Care Expansion grant, which it used in partnership with LME-MCOs to pilot a High Fidelity Wraparound (HFW). HFW is an evidenced-informed supportive service carried out by a North Carolina Wraparound Team for youth ages 3-20 with serious emotional disturbance or a serious emotional disturbance and a co-occurring substance use disorder and/or intellectual/developmental disability.

In the first year of the HFW pilot (April 2015 – March 2016), the target included 50 North Carolina youth transitioning from Psychiatric Residential Treatment Facilities (PRTFs) to a community-based setting, such as biological parents, kinship care, DSS foster home, therapeutic foster care, and independent living. HFW strongly encourages and advocates for collaboration between services with the goal of reducing the number of meetings a family must attend and ensuring that all involved parties have the same information regarding treatment goals, progress, and any barriers that need to be addressed. The HFW team's work includes conducting strength-based assessments, participating in the Child and Family Team held at the PRFT/Out-of-Home Placement and bringing community resources to include in the discharge planning process, developing the Child and Family Team that supports the family when the youth has returned to the home and community, and coordinating with the family to increase natural supports during the transition process. The Child and Family Team develops combined agendas and their work culminates in the creation of a comprehensive treatment plan that includes support in the youth's school, home, and community.

There are currently five pilot sites that are working with youth and families, and the pilot teams are collecting outcomes in addition to completing consistent SAMHSA and Observation Measures Surveys with their families and youths to assess the effectiveness and impact of HFW pilot.

Transitions to Community Living Initiative

Transitions to Community Living Initiative (TCLI) is the product of a 2012 settlement between the United States Department of Justice and the State of North Carolina. TCLI focuses on the goal of recovery and community inclusion, supported through the mental health consumer movement's advocacy on the roles of self-determination and peer supports to enhance quality of life.

Individual Placement and Support
A component of TCLI is the Individual Placement Support- Supported Employment (IPS-SE) evidence-based, behavioral health service for adults with SMI and co-occurring M/SUD. IPS teams take a holistic approach to finding competitive employment, by learning about their career goals, determining barriers to achieving those goals and working together to overcome those barriers, co-developing a person-centered plan, working together on their job search, and continuing to provide support after securing employment. Of note, IPS is unique in that the job search is centered around the preferences of the person as opposed to market availability, and following-along with the person after securing employment to address any challenges to their continued employment. By co-creating custom plans based on the aspirations and wants of people served, they are more likely to find lasting employment and feel like valued members of the community.

There are currently 36 IPS teams providing the service across the state. DMH/DD/SAS actively
partners with the Division of Medical Assistance and the Division of Vocational Rehabilitation to ensure that fidelity based practice is supported by all divisions. DMH/DD/SAS also partners with stakeholder
groups, including: NAMI and Employment First NC to increase awareness of IPS-SE across the state and ensure that these stakeholder groups have information to advocate for this service. DMH/DD/SAS and The UNC Center for Excellence in Community Mental Health provides training and technical assistance to IPS teams. Finally, North Carolina is a member of the Rockville Institute IPS Learning Community, which provides technical assistance and support not only from other states and countries implementing this service, it provides a direct means of communication with the organization that developed and researched this model.

Feedback received from community meetings and trainings indicates that the employment focus and employment first philosophy is a major paradigm shift for North Carolina's system of care. There is clearly a need for hands-on systematic training and mentorship to understand the model and shift agency practices. There is also need for stronger focus on removing barriers, such as "readiness thinking," through continuing education and research dissemination, and on improving benefits counseling with

individuals and their families, as well as improving job development using the dual customer approach with employers. DMH/DD/SAS is in the process of developing and piloting outcome-based reimbursement for IPS-SE services to incentivize providers to closely practice the IPS-SE model.

Assertive Community Treatment (ACT)

ACT is an evidence-based practice that is comprehensive and includes a multi-disciplinary clinical team that utilizes the expertise of medical, therapeutic, social work, vocational, substance abuse and peer support professionals to assist individuals diagnosed with SPMI to achieve and sustain recovery in the community of their choice. ACT services are holistic, frequent, intensive and provided directly in the community to enhance the overall quality of life through building self-confidence and proficiency across all domains of life functioning. ACT brings comprehensive psychiatric rehabilitation supports to individuals where they live to teach independent living skills to aid the individual in integrating into their community.

The UNC Center for Excellence in Community Mental Health provides training and technical assistance to ACT teams. The North Carolina ACT Coalition is a grassroots provider group that started in 2006, and has been coordinated by Dr. Lorna Moser since 2009, that meets every other month in the western and eastern regions of the state giving providers a resource for peer support, advocacy, mentorship, and guidance.

Tenancy Support Services (TSS)

The State ensures that TSS is provided to individuals transitioning to their own homes. Training for Tenancy Support staff is provided on psychiatric rehabilitation to assist individuals with learning skills to live and thrive in the community. DMH/DD/SAS works with the Center for Social Innovation's T3 Training consultants, which provides easily accessible and highly tailored training. Trainings have been offered to LME-MCO TCL staff, housing specialists, care coordinators, peer support specialists, ACT teams and housing staff on Permanent Supportive Housing and Housing First models, motivational interviewing, working with landlords, conducting home visits, responding to crises, and the principles of the tenancy support approach.

Please indicate areas of technical assistance needed related to this section.

The Project Manager and State implementation staff in partnership with the pilot sites will be receiving technical assistance from the Wraparound Implementation Center in September 2017 for a range of topics from High Fidelity Wraparound model fidelity to infrastructure and financing management. In addition to this the state project management team will receive HFW consultation and technical assistance from other university partners related monitoring and oversight of model fidelity.

ACT teams can benefit from technical assistance in the areas of engaging natural supports, daily team meeting processes, evidenced-based practice implementation and systematic implementation of psychiatric rehabilitation interventions.

Footnotes:

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1.   Does the state's Olmstead plan include :

      housing services provided.   ○ Yes ○ No

      home and community based services.   ○ Yes ○ No

      peer support services.   ○ Yes ○ No

      employment services.   ○ Yes ○ No

2.   Does the state have a plan to transition individuals from hospital to community settings?   ○ Yes ○ No

3.   What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

      Does the state have any activities related to this section that you would like to highlight?

      Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21[69]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:
1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

• non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);

• supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

[66]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[67]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593?602.

[68]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[69]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[70]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010**

[71] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1.   Does the state utilize a system of care approach to support:

   a) The recovery and resilience of children and youth with SED?   ⊙ Yes ○ No

   b) The recovery and resilience of children and youth with SUD?   ⊙ Yes ○ No

2.   Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

   a) Child welfare?   ○ Yes ⊙ No

   b) Juvenile justice?   ⊙ Yes ○ No

   c) Education?   ○ Yes ⊙ No

3.   Does the state monitor its progress and effectiveness, around:

   a) Service utilization?   ⊙ Yes ○ No

   b) Costs?   ⊙ Yes ○ No

   c) Outcomes for children and youth services?   ⊙ Yes ○ No

4.   Does the state provide training in evidence-based:

   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?   ⊙ Yes ○ No

   b) Mental health treatment and recovery services for children/adolescents and their families?   ⊙ Yes ○ No

5.   Does the state have plans for transitioning children and youth receiving services:

   a) to the adult behavioral health system?   ○ Yes ⊙ No

   b) for youth in foster care?   ○ Yes ⊙ No

6.   Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

NC DMHDDSAS has focuses its System of Care efforts in the following areas:

Improving Coordinated Care for Individual Youth and their Families
To improve the coordination of care for youth with the most complex needs, High Fidelity Wraparound is being piloted currently in five sites in North Carolina through both a SAMHSA-funded System of Care Grant and through a new legislative allocation to support recommendations from a Governor's Task Force on Mental Health and Substance Use Disorders.

To improve care coordination for youth with moderate and high level needs, case management is embedded in the service definitions for community based services (Intensive In-Home Services, Multi-Systemic Therapy, and Day Treatment) and residential treatment. Youth in those services as well as youth in the custody of social service have a Child and Family Team comprised of the people who know the child best and who can be instrumental in supporting the child and family in identifying and meeting their needs. Within the last year, NC State Collaborative for Children, Youth, and Families has revised the training for Child and Family Teams and its attendant Training of Trainers to further support the coordination of care through Child and Family Teams.

Improving Coordination across Systems
To improve coordination across systems, NC has a structure of 73 Community Collaboratives and the statewide Collaborative for

Children, Youth and Families. The Community Collaboratives are staffed by 25 System of Care Coordinators employed by the behavioral health managed care organizations and partially funded through state funds. A statewide System of Care Coordinator supports the local System of Care Coordinators and is one of several DMHDDSAS liaisons with the State Collaborative.

Both the State Collaborative and the local Community Collaboratives work to identify barriers to coordination of care for multi-agency involved youth and address those barriers.

In addition, DMHDDSAS convened a Cross System Workgroup of mid-level managers from state agencies along with family representation to prioritize state level recommendations from a series of other workgroups and to develop an action plan to address shared priorities.

Improving Family Engagement and Support
DMHDDSAS contracts with a statewide family organization, NC Families United, to provide training and technical assistance on family engagement for individual family service planning as well as statewide policy making. NC Families United is heavily involved in state-level policy development and evaluation. DMHDDSAS also contracts with NC Families United for NC Youth Move as well as for youth leadership training.

The State SOC Coordinator works with local SOC Coordinators to improve their family and youth representation on local Community Collaboratives. The State Collaborative continues to promote its family-Driven Child and Family Team training which is co-trained by an agency and family member training team.

Enhancing and Improving the Array for Community Services
DMHDDSAS is preparing Medicaid and state funded service definitions to sustain its High Fidelity Wraparound pilots. The Governor's Task Force recommended and the state legislature funded multiple pilot sites to integrate High Fidelity Wraparound, targeted case management, and MCO (Managed Care Organization) care coordination into a seamless system for juvenile justice and child welfare involved youth.

DMHDDSAS is also focusing on improving crisis services through start-up funding for three new child facility based crisis centers. In addition, DMHDDSAS is promoting behavioral health urgent care centers and is revising its mobile crisis definition to be more responsive to children's needs.
DMHDDSAS has a multi-year partnership with the Center for Child and Family Health to provide learning collaboratives to train clinicians in evidenced based trauma interventions. The Center for Child and Family Health has focused on the following interventions: Trauma Focused Cognitive Behavior Therapy, SPARCS (Structured Psychotherapy for Adolescents Responding to Chronic Stress), Child Parent Psychotherapy, and Parent Child Interaction Therapy. This array of interventions provides age coverage from 0-18 years. By providing learning collaboratives that last from 12-18 months depending on the model and by supporting senior leaders within the provider agencies, the Center for Child and Family Health aims to ensure fidelity to these evidence based trauma models long after the initial training.

DMHDDSAS also aims to ensure that services are culturally and linguistically responsive. To that end, DMHDDSAS has started a Health Disparities Workgroup which has provided training and technical assistance to selected sites as they develop local plans to address health disparities their communities.

7. Does the state have any activities related to this section that you would like to highlight?

DMHDDSAS staff have been heavily involved in school based mental health workgroups which convened multiple listening sessions and have developed policy to support the development of and the referral system to behavioral health services. Increasing behavioral health services within schools will increase early identification and treatment of behavioral health concerns.

In addition, DMHDDSAS continues to spread Mental health First Aid training including the sponsoring two upcoming Youth Mental Health First Aid Instructor trainings for staff from the Department of Public Instruction.

DMHDDSAS is also a partner in a statewide structure to support local Juvenile Justice Substance Use Mental Health Partnerships which provide training in using local data and in evidence based interventions to improve services and supports for young people with behavioral health challenges within the juvenile justice system.

DMHDDSAS partners with the Division of Social Services in a variety of initiatives including a multi-county trauma informed care pilot (Project Broadcast), a Child Wellbeing Collaborative which was focused on system level improvement such as improved data sharing, and the development of DSS' Performance Improvement Plan and overall DSS strategic plan following their federal review.

Please indicate areas of technical assistance needed related to this section.

• Interface between child welfare and mental health on the state and local levels
• High Fidelity Wraparound implementation
* Implementing a sustainable early childhood mental health system of care across agencies, especially early childhood consultation
* Integrating sustainable consumer, family and youth voice, partnership and peer health navigators core SOC in a privatized

managed care arena.

<table>
<tr><td>**Footnotes:**</td></tr>
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Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years?　　　　　　⦿ Yes ○ No

2. Describe activities intended to reduce incidents of suicide in your state.

    In addition to statewide awareness and gatekeeper training and Mental Health First Aid training.

    Exploring and planning implementation of effective prevention strategies with the following populations:
    -school age students (legislation proposed for requiring suicide prevention training for all school personnel interfacing with students);
    -Veterans, National Guard, military members and family members (1 in 5 die by suicide in NC)
    - those who experience Opioid Misuse and Overdose (counseling on access to lethal means-CALM; 1 in 6 are intentional deaths)
    -NCIOM Task Force study and recommendations regarding adolescents and older adults
    -individuals experiencing crisis
    -individuals in ED and those discharged
    -first responders

3. Have you incorporated any strategies supportive of Zero Suicide?　　　　　　⦿ Yes ○ No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?　　　　　　⦿ Yes ○ No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted?　　　　　　⦿ Yes ○ No

    If so, please describe the population targeted.

    Exploring and planning implementation of effective prevention strategies with the following populations:
    -school age students (legislation proposed for requiring suicide prevention training for all school personnel interfacing with students);
    -Veterans, National Guard, military members and family members (1 in 5 die by suicide; 5 die weekly, more attempt in NC)
    - those who experience Opioid Misuse and Overdose (counseling on access to lethal means-CALM; 1 in 6 are intentional deaths)
    -NCIOM Task Force study and recommendations regarding adolescents and older adults
    -individuals experiencing crisis
    -individuals in ED and those discharged
    -first responders
    -NC Tribal communities and youth experiencing behavioral health and life course challenges
    -Making connections with SUD and Opioid Misuse and Overdose and untreated trauma and suicide prevention

    Does the state have any activities related to this section that you would like to highlight?

    Pilot state-funded case management services for those most in need and community re-entry

    School Mental Health Initiative

    Exploring the implementation of CALM and safety planning as a routine component across practice settings

    Exploring CRM - Community Resilience Model across settings in communities and with target populations

    Focus on veterans, National Guard, military & family members

Please indicate areas of technical assistance needed related to this section.

To be determined as the plan is implemented.

Footnotes:

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;

- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;

- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;

- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;

- The state public housing agencies which can be critical for the implementation of Olmstead;

- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and

- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?   ⦿ Yes ◯ No

2. Has your state identified the need to develop new partnerships that you did not have in place?   ⦿ Yes ◯ No

If yes, with whom?

The SMHA has established a public academic liaison (PAL) with Duke Unversity and law enforcement agencies among other community crisis coalition stakeholders, families and advocates in implementing a Pediatric Psychiatric Law Enforcement Transport Model Pilot to reduce trauma experienced by children, youth and young adults requiring psychiatric diagnostic services and/or transition to/from community services.

The SMHA is building a relationship with the National Center for Homeless Education and the NC Center for Homeless Education (SERVE) at UNC-Greensboro http://center.serve.org/hepnc/

The SMHA is working with partners to better address Children with Complex Needs https://www.ncdhhs.gov/about/department-initiatives/children-complex-needs

The SMHA is strengthening relationships with the State Independent Living Council and their networks across the state to promote IPS and benefits counseling in addition to working with family and youth peers and advocates to promote and sustain successful employment opportunities.

The state's office of emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their

families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

School Mental Health Initiative (SMHI) - The SMHA is actively working with state DPI and LEAs/IDEA and DMA-Medicaid in exploring ways in which mental health services can become sustained and part of the child mental health service array, including early childhood mental health consultation and related services for older school age students with behavioral health needs.

Education Services for children and youth in PRTFs (psychiatric residential treatment services) - The SMHA has actively established contracts with PRTFs for the provision of educational services meeting NC DPI (public school) and IDEA requirements. Joint work with NC DPI, Division of Exceptional Children (IDEA) and the NC Office of Non-Public Schools and the eligible licensed and registered PRTFs. joint training, implementation and monitoring of educational services is in place.

Early Childhood and Early Childhood Mental Health Consultation - The SMHA is an active partner in implementing three different technical assistance awards in addressing challenging behaviors and intervening early with very young children who have serious emotional and social development needs and whose families have complex needs. Services and supports are being defined across agencies for this population. All departments and the legislature have studied and are interest in implementing and sustaining an ECMH System of Care for young children across systems.

Cross-system workgroup- an interdepartmental child and family focused workgoup that includes family and youth members has been established to promote common practice models, develop complementary services and supports, and problem solve in order to work more efficiently with limited resources, especially for the most serious in need and those with complex needs.

Medicaid Reform - The 1115 Demonstration Waiver Application, also known as Medicaid Reform -- North Carolina submitted its application on June 1. Over the next 18 months or so, CMS will review the application and discuss the reform plan in detail with the Department of Health and Human Services. Over the next three to four years, the NC Department of Health and Human Services will work closely with people who receive Medicaid services and their families, and with those that provide Medicaid and NC Health Choice services (such as doctors and hospitals) to build the new Medicaid health care system. In the meantime, the Medicaid program will continue as usual, and beneficiaries will receive care the same way they do now.

Does the state have any activities related to this section that you would like to highlight?

Child Welfare - Child and Family Services Performance Improvement Plan and pending legislation that supports the NC Department of Social Services and local county DSS work together with interagency partners and recipients of services across the state to address federal review findings that aim to
--ensure conformity with federal (and state) child welfare requirements
--determine what is actually happening to children and families as they are engaged in child welfare services
--enhance the state's capacity to help children and families achieve positive outcomes
https://www.ncdhhs.gov/child-and-family-services-performance-improvement-plan

NC Collaborative for Children, Youth and Families and Community Collaboratives – The SMHA and LME/MCOs among other partners actively engage in collaborative work with the system of care (SOC) framework at the core. Provides a forum for identifying and discussing issues regarding how agencies, youth, and families can work together to produce better outcomes for children, youth and families. The collaborative develops recommendations regarding the coordination of services, funding, training and local reporting requirements to eliminate duplication and make the system more consumer friendly; includes representatives of a range of state and local agencies, youth, families, and advocates; and provides support for 82 local community collaboratives and implementation of Child and Family Teams. During the next year, regional learning institutes will be convened across the state with a broad set of stakeholders to promote regional and community connections and advocacy in system development. The Collaborative brings family and youth leaders and voices to tables across systems.
https://nccollaborative.org/

School Mental Health Initiative (SMHI) - The State Board of Education (SBE) approved a new policy in April 2017 to help improve mental health services for public school students in North Carolina. Research shows that nearly 1 in 5 students will experience a mental health disorder in any given year in North Carolina. Of those students, 75 percent or nearly 227,000 students are not likely to receive treatment. In addition, the total number of youth suicides in North Carolina has doubled in recent years. This initiative is an interagency, youth and family statewide effort to review the data, formulate draft policy and implement the policy in partnership with the state Department of Public Instruction (DPI) which is over all local education agencies (LEAs) and public school entities and implementation of IDEA. https://www.ednc.org/2017/05/18/new-policy-addresses-mental-health-needs-public-school-students/

Opioid Misuse and Overdose Prevention under the Cures Act - On May 1, 2017, North Carolina received $15,586,724 to address the opioid crisis through the 21st Century Cures Act, State Targeted Response to the Opioid Crisis Grants. The Substance Abuse and Mental Health Services Administration (SAMHSA) awarded the grant to the N.C. Department of Health and Human Services (DHHS) Division of Mental Health, Developmental Disabilities and Substance Abuse Services to increase access to prevention, treatment and recovery supports, reducing unmet treatment need, and reducing opioid-related overdoses and deaths.
? Eighty percent of these funds must support outreach, engagement, treatment and recovery services.
? Grant funds are expected to serve at least 1,460 individuals in the first year.
This grant allows North Carolina to serve a greater number of individuals experiencing opioid use disorders and expand the number of medication-assisted treatment and opioid use disorder treatment providers into the future. Interdisciplinary partnerships are strengthening through this effort among SUD prevention and treatment, and MH and key community stakeholders and non-traditional partners.

Raise the Age for Adult Court for Juveniles - North Carolina is the last state to raise the age for adult court for juveniles in June 2017. Crimes alleged to have been committed by those age 16 and older in North Carolina are currently heard in adult court; in 2017 North Carolina became the final state to "Raise the Age" for nonviolent offenses to 18, effective in late 2019. Interagency, family and youth partners statewide worked tirelessly on this issue. The state legislature added the sweeping juvenile justice reform to a vote on the final state budget, rather than as a standalone bill; lawmakers on both sides of the aisle joined forces to make the changes. https://www.ncdps.gov/our-organization/juvenile-justice/key-initiatives/raise-age-nc

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[72]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[72]**http://beta.samhsa.gov/grants/block-grants/resources**

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

   See letter of support

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i   ○ Yes ● No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)?   ● Yes ○ No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   The Planning Council meets bi-monthly. The minutes of these meetings will reflect that the Council receives regular reports from NC DMH/DD/SAS on issues such as needs assessment, service gaps, and consumer satisfaction. Each November a special meeting is called so the Council can review and approved the annual report. During the SAMHSA application process, the council is breifed on the state plan, and prior to submission the plan is review and accepted by the Council. Minutes of the Council meetings will reflect these activities.

   Does the state have any activities related to this section that you would like to highlight?

   The SMHA staff participated as part of the NCMHPAC Leadership Academy TA Team in support for Council development.

   Please indicate areas of technical assistance needed related to this section.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

[73]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

North Carolina Mental Health Planning and Advisory Council

August 30, 2017

Dr. Jason Vogler
Senior Director of MH/DD/SAS
3001 Mail Center
Raleigh, NC 27699-3001

Dear Dr. Vogler:

The NC Mental Health Planning and Advisory Council (NCMHPAC) reviews the current year and trends data and services provided to children with serious emotional disturbance and adults with serious mental illness for whom the Community Mental Health Services Block Grant is intended to serve. We believe it is essential to reinforce and strengthen the public safety net for those of all ages who are most in need of services and supports and who cannot access them through Medicaid or other third parties. We believe utilization of these federal block grant and state funds to support an effective responsive public safety net is essential.

We believe an effective, responsive system openly engages children, youth, adults, and families as peers and partners. We support an effective coordinated recovery oriented system of care of services and supports that builds resilience for children and youth with serious emotional disturbance and adults with serious mental illness delivered efficiently, using limited resources to meet the growing needs in our communities.

As a collective, we carefully consider the varied experiences and expertise we each bring to the Council; our work and life in communities is extensive. Many of us and those we represent are involved in statewide and community initiatives and in related advisory groups.

We reviewed plan components and identified priorities for the two-year SFY18-20 plan. Throughout the year, meetings focused on plan elements. Modifications to the measures, indicators and targets were made and are reflected in the plan. The Council's decisions and recommendations were based on the data reviewed, and the gaps and needs identified by the Local Management Entities-Managed Care Organizations (LME-MCOs) and provider networks that were reported to the Division and in turn reported to the Council. We pursued, reviewed and considered broad based stakeholder comments through a Council electronic survey and are drafting a new survey for the new plan year. We continue to seek public comment through various forums as a standing agenda item at each Council meeting.

This year, the Council established a committee to review the plan, endorse recommendations of the Council to the division, and in the future this committee will continue the ongoing review of the adequacy of block grant allocations, innovation and mechanisms for sustainability. By consensus, at the August 4th meeting the Council recommends the following priorities for all populations be considered:

- Expand and implement sustainable models for certified peer specialists, family partners, and youth/young adult peer partners and innovative ways in which peers, and peer-run services can be funded, embedded and sustained in communities to meet gaps and build on strengths. We can improve outcomes and explore sustainable solutions when we engage and promote synergy across our diverse consumers, youth and family partnerships. These partnerships offer possibilities for engaging in new opportunities (e.g., health coaching, case management skills, life skills management, health navigators, basic disease management, Healthy Ideas for suicide prevention) and other examples such as those outlined in *A Partnership for Culture Change A Report of the NCIOM Task Force on Patient and Family Engagement* (NCIOM, 2015) http://www.nciom.org/wp-content/uploads/2015/07/PFE-Report-FINAL.pdf and in the *Suicide Prevention and Intervention Plan: A Report of the NCIOM Task Force on Suicide Prevention and Intervention* (NCIOM, 2012) http://www.nciom.org/wp-content/uploads/2012/08/SuicidePrev-report_web.pdf .
- Spend mental health block grant funds on needs to meet public safety net, increase access, reduce behavioral health disparities, and monitor and document these expenditures and outcomes to demonstrate impact, to make adjustments as needed, and support sustainability.
- Create and sustain structures for meaningful consumer and family voice/input (i.e., advisory, leadership and decision-making forums) going forward in varied proposed local, health and behavioral health care administration and state levels.
- Create and sustain a process to build the capacity to fund innovation and incorporate sustainability including but not limited to: phasing in next steps/documenting implementation frameworks for scale up of models in other parts of the region and state, replicating, sharing expertise and providing technical assistance to replicate site.
- Embrace as the NCMHPAC embraces community inclusion (i.e., as outlined in *Well Together – A Blueprint for Community Inclusion: Fundamental Concepts, Theoretical Frameworks and Evidence,* Salzer & Baron, 2016) and growing a healthy well able North Carolina from the youngest infant, toddler and preschooler to the oldest individual; students; those parenting; vets and active military and their families and caregivers; those most serious and those most at risk in their life course. https://media.wellways.org/inline-files/Well%20Together_2%20May%202016_Final_Web_0.pdf.
- Embrace, create and sustain Community Resilience Model such that statewide mental health promotion and mental health recovery is both possible and the norm.
- Implement proactive and culturally responsive strategies to strengthen resilient communities and specifically lessen contacts with law enforcement and the legal and justice system as well as death disproportionately impacting health communities of color.
- Equip and strengthen community capacity for using tools for recovery, addressing health disparities and promoting natural supports, sufficiency especially in light of the current highly politically charged climate. Some examples include scaling up across the state the use of adaptable evidence-based wellness tools such as Wellness Recovery Action Plan (WRAP)

skills and other exceptional and accessible models to promote statewide mental health recovery action agenda.

The Mental Health Planning Council is a vital resource and available as the division implements different though related plans including: this two-year block grant plan, the DMHDDSAS annual strategic plan and as the DHHS strategic behavioral health plan for the community and facility-based service system is implemented beginning January 1, 2018. The Council is an invaluable resource related to access, navigating complex systems special populations, and integration of whole-person quality coordinated care. We know there is much to be done to meet the unmet needs in North Carolina. We look forward to opportunities to offer recommendations aimed at improving outcomes for consumers, youth and their families as this two-year plan is implemented and a public safety net is strengthened in future state reforms.

By this letter, we affirm our active role with the NC DMHDDSAS in planning for the priorities and strategies of the SFY18-20 plan. In so doing, we are mindful and extremely concerned for the significant proposed reduction in the mental health block grant funding to our state. We believe this reduction will significantly impact the state's public safety net and impede facilitating innovative person-centered and peer, youth and family driven service system that we collectively envision.

Sincerely on behalf of the NCMHPAC,

Damie Jackson-Diop, Chair

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018   End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Amy Batel	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Bert Bennett	State Employees	Division of Medical Assistance Programs		
Gwen Bercaldi	State Employees	NC Housing & Finance Agency		Gbercaldi@nchfa.com
Gail Cormier	Parents of children with SED	NC Families United, NCFFCMH, Inc.		gcormier@triad.rr.com
Tammy Deppe	Parents of children with SED			
Damie Diop-Jackson	Parents of children with SED	NC Families United		djackson@gmail.com
Lucy Dorsey	Providers	Sandhills Center		Lucy.dorsey@sandhillscenter.org
Mary Edwards	State Employees	NC Divison of Aging and Adults Services		mary.edwards@dhhs.nc.gov
John Hanichak	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Nicholle Karim	Others (Not State employees or providers)	NAMI		
Kevin Kelley	State Employees	NC Division of Social Services		
Mary Lloyd	Parents of children with SED	NC Families United, NCFFCMH, Inc.		lloymary@smokymountaincenter.com
Barbara Maier	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Jennifer Overfield	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Wes Rider	State Employees	NC Division of MHDDSAS		wes.rider@dhhs.nc.gov
Garron Rogers	Providers			
Terri Shelton	Others (Not State employees or providers)	UNC-Greensboro		
Joe Simmons	State Employees	NC DPI		jsimmons@dpi.state.nc.us

Vicki Smith	Others (Not State employees or providers)	Disablity Rights NC		vsmith@disabilityrightsnc.org
Jean Steinberg	State Employees	NC Department of Public Safety/Division of Juvenile Justice		jean.steinberg@ncdps.gov
Jim Swain	State Employees	Division of Vocational Rehabilitation		
Dave Wickstrom	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Marcus Wilson-Stevenson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Ralph Wright-Murray	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018   End Year: 2019

Type of Membership	Number	Percentage
Total Membership	**24**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	6	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	1	
Parents of children with SED*	4	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	3	
Total Individuals in Recovery, Family Members & Others	**14**	**58.33%**
State Employees	8	
Providers	2	
Vacancies	0	
Total State Employees & Providers	**10**	**41.67%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Persons in recovery from or providing treatment for or advocating for substance abuse services	0	
Federally Recognized Tribe Representatives	0	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

   a)   Public meetings or hearings?   ⦿ Yes ○ No

   b)   Posting of the plan on the web for public comment?   ⦿ Yes ○ No

            If yes, provide URL:

            https://www.ncdhhs.gov/divisions/mhddsas/grants/mental-health-block-grant

   c)   Other (e.g. public service announcements, print media)   ○ Yes ⦿ No

Footnotes: